

0-04629

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

12512

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <i>Ruby Mae Barnhart</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>4 16 86</i>		2b. HOUR <i>6 PM</i>	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 4, 1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>shoe</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Roy B. Starn</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Esther Rogers</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS <i>Pauline Lehman, Hagerstown, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetic mellitus</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Severe arteriosclerotic cardiovascular disease</i>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/16</i> 19 <i>86</i> to <i>4/16</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>has not seen</i> <i>PT</i> <i>4/16</i> above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Allen D. H. M.D.</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>4/16/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Allen D. H. M.D.</i>		22e. ADDRESS <i>1610 Oak Hill Avenue Hagerstown MD</i>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>Apr. 19, 1986</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>		24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>		25. ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>	

APR 22 1986

1. List

2. List

3. List

4. List

5. List

6. List

7. List

00-06265

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12513

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Yolanda</i>		MIDDLE <i>M</i>		LAST <i>Michell</i>		2b. DATE KNOWN OF DEATH ESTIMATED		MONTH <input checked="" type="checkbox"/> 4		DAY <i>27</i>		YEAR <i>1986</i>		2b. HOUR <i>11:40</i>			
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 10, 1971</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>14</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <i>4 27 1986</i>		MONTH DAY YEAR		2d. HOUR <i>11:40</i>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.							
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>student</i>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>				13b. CITY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>541 Ridge Ave.</i>				21740					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Roland Lee Billman, Sr.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Stella C. Shifflett</i>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-08-1969</i>				17. INFORMANT ADDRESS <i>R. L. Billman, Sr., Hagerstown, Md.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8169 IMMEDIATE CAUSE (a) <i>Hypovolemic shock N458</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Amputation of leg (traumatic) N897</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Motor vehicle accident - ran off road F816</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i> <i>seconds</i>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>Infection liver/spleen, ruptured aortic arch</i>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <i>6500 4 27 1986</i>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>6500 4 27 1986</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Car ran off road - struck bridge</i>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Road</i>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Williamsport Pike Frankla PA</i>											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Allen D. H. MD</i>				TITLE (SPECIFY) <i>Dept Assist</i>				M.D. MEDICAL EXAMINER				DATE SIGNED <i>4/29/86</i>							
EXAMINER'S NAME (TYPE OR PRINT) <i>Allen D. H. MD</i>				ADDRESS <i>1610 Oak Hill Ave Hagerstown MD</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>				23b. DATE <i>May 1, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Lawn Mem. Park</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>									
24. FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</i>								25a. DATE REC'D. BY REGISTRAR <i>MAY 08 1986</i>								25b. REGISTRAR'S SIGNATURE <i>James A. ...</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 101.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

00-05245

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official certifying and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove common papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 1 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ORA LAURA BRADFELD			2a. DATE OF DEATH MONTH DAY YEAR 4/23/86			2b. HOUR 3:50 AM		
3. SEX F		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR 11 20 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.		
10. CITY OR TOWN OF DEATH Bonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reid's Memorial Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Domestic		
13a. STATE W. Va.		13b. COUNTY Hardy		13c. CITY OR TOWN Baker		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Ashby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Elizabeth Davidson		13e. STREET ADDRESS Rural Route 9999				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-74-1009		17. INFORMANT ADDRESS 13121 Grenable Dr. Mrs. Mescal Wimberly, Rockville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic infarct by arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Andrew J. Gunn MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/23/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew J. Gunn				22e. ADDRESS 100 Greeting Ln. P.O. Box 246 Keatysville, Md. 21756				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baker Hardy W. Va.		
24. FUNERAL DIRECTOR NAME James R. Giles				ADDRESS Augusta, W. V 26704		25a. DATE REC'D. BY REGISTRAR APR 30 1986		
25b. REGISTRAR'S SIGNATURE Julia Davidson								

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00-03927

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8612515
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Helen		MIDDLE Campell		LAST Brown		2a. DATE OF DEATH MONTH DAY YEAR 4/10/86		2b. HOUR 10A ³⁰ M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7/14/1894		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS 8 3		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.							
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -							
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 Catawba Place		21740			
14. FATHER'S NAME FIRST MIDDLE LAST George Washington Campell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Dressler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-74-8878		17. INFORMANT June Stewart, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 3 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Parkinson's; Recent Fracture right hip													
19a. DATE OF OPERATION 3/12/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture rt hip		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 3/9/96 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Patient fell at her home									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5 Catawba Place Hagerstown, Md.									
22a. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1972, to Apr. 10, 1986, that (I) (we) last saw the deceased alive on Apr. 10, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE W. W. Lesh		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-10-86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William W. Lesh M.D.		22e. ADDRESS 411 Division Ave Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd. Hagerstown, Md. 21740													

APR 16 1986

10A	4/10/86	Brown	C	Helen
8	91	2/10/1894	White	Female
Washington	X	USA		
Housewife		Avalon Nursing Home		Hagerstown
5 Carwaps Place		X		Maryland Washington Hagerstown

215-74-8878

Stroke
Pneumonia
1 hr
3 days

Parkinson's; Recent Fracture right hip

3/12/86	Fracture rt hip	X
3/9/86	Patient fell at her home	
Home		X
Nov. 21	5 Carwaps Place Hagerstown, Md.	
Apr. 10	Apr. 10	

William W. Nash M.D.
411 Division Ave Hagerstown, Md.
4-10-86

0-04656

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other trauma, the medical examiner must be notified (p. 10)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE Gerald Thomas Buffington										APR 19 1986 REG. NO. 1986		1 2 5 1 6	
1. DECEASED NAME (TYPE OR PRINT) Thomas						2a. DATE OF DEATH MONTH DAY YEAR 7 17 86				2b. HOUR 2:17 AM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.							
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) furniture		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7 Berner Avenue 21740			
14. FATHER'S NAME FIRST MIDDLE LAST George Buffington				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Valley French									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 219-20-2064		17. INFORMANT ADDRESS Flora Buffington, Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for each of the four lines) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (b) the presence of atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease (d) Coronary artery disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE PARK, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)									
22a. I certify that (I) (this hospital) attended the deceased from 7-4 19 86 to 19 19 86 that (I) (we) last saw the deceased alive on 7-4 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) see the body after death.													
22b. SIGNATURE E. J. Bordin						DEGREE MD		22c. DATE SIGNED 4-17-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. J. Bordin						22e. ADDRESS 282 E. W. Wilson Blvd., Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 21, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.							
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 4415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE [Signature]					

0-104822



RECEIVED
MAY 11 1964
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HONOLULU, HAWAII

U.S. AIR FORCE
HONOLULU, HAWAII

00-05686

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12517
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Paul S. Byers			2a. DATE OF DEATH MONTH DAY YEAR April 28, 1986		2b. HOUR 3:30 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 28 1906		
6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		9b. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD		10. CITY OR TOWN OF DEATH Hagerstown		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor		12b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY West Virginia Berkeley		13b. CITY OR TOWN Hedgesville		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Henry L. Byers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Rockwell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 234-01-8425		17. INFORMANT Mrs. Janet Cookus		ADDRESS Rt. 6, Box 258 Martinsburg, WV 25401		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Radiation Fibrosis.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from 79 to April 1986 , that (I) (we) last saw the deceased alive on April 27, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22a. SIGNATURE Gloria F. Pura		DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 4/28/86		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) GLORIA F. PURA		22e. ADDRESS 339 E. Infector St. Hagerstown				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 5/1/86		23c. NAME OF CEMETERY OR CREMATORY Pleasant View Memory Cds. Martinsburg Berkeley WV		
23d. LOCATION CITY OR TOWN COUNTY STATE Berkeley WV		24. FUNERAL DIRECTOR Charles M. Brown		25a. DATE REC'D. BY REGISTRAR MAY 06 1986		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		ADDRESS 327 W. King St Martinsburg, WV				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon paper and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FEB 10 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

RECEIVED LIBRARY

WINTER 1964



00-02801

FOR
STATE
REGISTRARPHOEBE IRENE
CARBAUGHDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

12518

1. DECEASED NAME (TYPE OR PRINT) PHOEBE IRENE CARBAUGH		2a. DATE OF DEATH MONTH DAY YEAR 4-3-86		2b. HOUR 3 50 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 17, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Clear Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles Franklin Perry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phoebe Jane Poole		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---	17. INFORMANT ADDRESS Box 76 Wilbur F. Carbaugh Maugansville, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **Coronary Heart Failure**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE D. Wheeler	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. WATKINS MD		22e. ADDRESS 1610- OAK Hill NE. HAGERSTOWN, MD 21740	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-5-86	23c. NAME OF CEMETERY OR CREMATORY Blairs Valley Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Clear Spring, Wash. Md.
24. FUNERAL DIRECTOR NAME Donald E. Thompson Funeral Home, Inc.		25a. DATE OF REGISTRATION APR 7 1986	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not at work," the medical examiner must be notified of this.

00-02804

PHONE 1821
CARMUCH

WASHE DEVE CARMUCH

May 17, 1901

White

Washington County

West Virginia U.S.A.

Hopewell

Washington County

27222

Route 2 Box 171

Washington Clear Spring

Pool Lane

Charles Franklin Perry

Box 75
100-02-1875 William F. Carlsough Manassas, Md.

1871 10-100-02-1875

Burial

4-5-02

Clear Spring, Md.

Douglas E. Thompson Funeral Home, Inc.

Elaine Valley Cemetery Clear Spring, Wash. Md.

00-05491

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please arrange for transportation of the body to the funeral home. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 5 1 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Woodrow Hauver Cline			2a. DATE OF DEATH MONTH DAY YEAR April 22 1986			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 12 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Taxi Driver		12b. KIND OF BUSINESS OR INDUSTRY Public Transp.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 225 S. Mont Valla Ave 21740	
14. FATHER'S NAME FIRST MIDDLE LAST John W Cline			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae T Hauver							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-7601		17. INFORMANT 225 S. Mont Valla Ave. Emma Cline Hagerstown, MD 21740					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Metastatic Cancer of prostate</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD, Asthma but not obstructive -</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/21/86</u> to <u>4/21/86</u> , that (I) (we) last saw the deceased alive on <u>4/21/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Francisco Androde</u>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Francisco Androde			22e. ADDRESS 363 S. Cleveland Ave Hagerstown MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-24-86		23c. NAME OF CEMETERY OR CREMATORY Garfield U. Methodist			23d. LOCATION CITY OR TOWN COUNTY STATE Garfield Frederick Maryland		
24. FUNERAL DIRECTOR <u>Ricketts Funeral Home</u>					ADDRESS Myersville, Maryland			25a. DATE REC'D. BY REGISTRAR MAY 01 1986		
					25b. REGISTRAR'S SIGNATURE <u>Julia Davidson Androde</u>					

BP



100% COTTON FIBER

MADE IN U.S.A.

0-05480

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 2 0
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Evelyn	MIDDLE Mabel	LAST CONRAD	2a. DATE OF DEATH MONTH DAY YEAR April 26, 1986	2b. HOUR 7:15 P M
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 1, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 36 Roessner Ave. 21740
14. FATHER'S NAME FIRST MIDDLE LAST John Stoner Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Keplinger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 46 7571		17. INFORMANT ADDRESS Evelyn Cronauer, Hagerstown, Md.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BASALOID CARCINOMA OF RECTUM WITH METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (CLOACOGENIC CARCINOMA) (b) <u>ANEMIA - SEVERE - DUE TO BLOOD LOSS FROM</u> DUE TO, OR AS A CONSEQUENCE OF <u>BASALOID CARCINOMA OF RECTUM</u> (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS 8 MONTHS
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) XXXXXX attended the deceased from <u>JAN. 16</u> , 19 <u>85</u> , to <u>APRIL 26</u> , 19 <u>86</u> , that (I) (X) last saw the deceased alive on <u>APRIL 25</u> , 19 <u>86</u> , and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (XX) (did not) view the body after death.					
22b. SIGNATURE <i>Edward W. Ditto, III</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED APRIL 29, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.		22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 30, 1986		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MAY 02 1986

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JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

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JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

00-04998

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 2 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE LILLIAN LAST COOL			2a. DATE OF DEATH MONTH DAY YEAR 4 / 22 / 86		2b. HOUR 1 55 P.M.						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 9, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9b. CITIZEN OF WHAT COUNTRY? U. S. A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.					
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPING		12b. KIND OF BUSINESS OR INDUSTRY ST. JOSEPH P.H.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY FREDERICK 13c. CITY OR TOWN EMMITSBURG						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE DEPAUL ST., 21727			
14. FATHER'S NAME FIRST JOHN MIDDLE BERNARD LAST WETZEL				15. MOTHER'S MAIDEN NAME FIRST NELLIE MIDDLE TOPPER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 177-26-6834		17. INFORMANT ADDRESS 21727-0545 G. ALBERT COOL, DEPAUL ST. EMMITSBURG, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PERIS, CORONARY ARTERY DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CHRONIC RENAL FAILURE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4-17, 19 86, to 4-22, 19 86, that (I) (we) last saw the deceased alive on 4-22, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eli Roza				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 22 APRIL 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELI ROZA				22e. ADDRESS WASHINGTON COUNTY HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 25 APRIL 86		23c. NAME OF CEMETERY OR CREMATORY NEW ST. JOSEPH'S		23d. LOCATION EMMITSBURG, FREDERICK, MARYLAND					
24. FUNERAL DIRECTOR NAME SKILES FUNERAL HOME, EMMITSBURG, MD 21727 ADDRESS				25a. DATE REC'D. BY REGISTRAR APR 28 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic, or other medical condition, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

100-40001

20% COTTON LIFES

CHIEF WATKINS



APR 28 1964

00-05209

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12522
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Charles MIDDLE Calvin LAST COSS		2a. DATE OF DEATH MONTH 4- DAY 26- YEAR 86		2b. HOUR 4:30A M	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH July DAY 17, YEAR 1902		6 AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Village		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) manager		12b. KIND OF BUSINESS OR INDUSTRY State Prison	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST William MIDDLE S. LAST Coss		15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE LAST Justice		13e. STREET ADDRESS / ZIP CODE 11 Woodside Drive 21740			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-36-2735		17. INFORMANT ADDRESS Mrs. Virginia H. Coss, Hagerstown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimer's Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>10 yrs</u>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Alzheimer's Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-17-86</u> to <u>4-26-86</u> , that (we) last saw the deceased alive on <u>4-17-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles F. Hess M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-26-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Hess M.D.				22e. ADDRESS Smithkline W.L. 21783.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE April 29, 1986		23c. NAME OF CEMETERY OR CREMATORY Ringgold Cemetery		23d. LOCATION CITY OR TOWN Ringgold, Washington, Maryland COUNTY STATE	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 East Wilson Blvd., Hagerstown, Maryland 21740				25a. DATE REC'D. BY REGISTRAR APR 30 1986 25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

20220-00

20% COTTON FIBER

00-04257

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

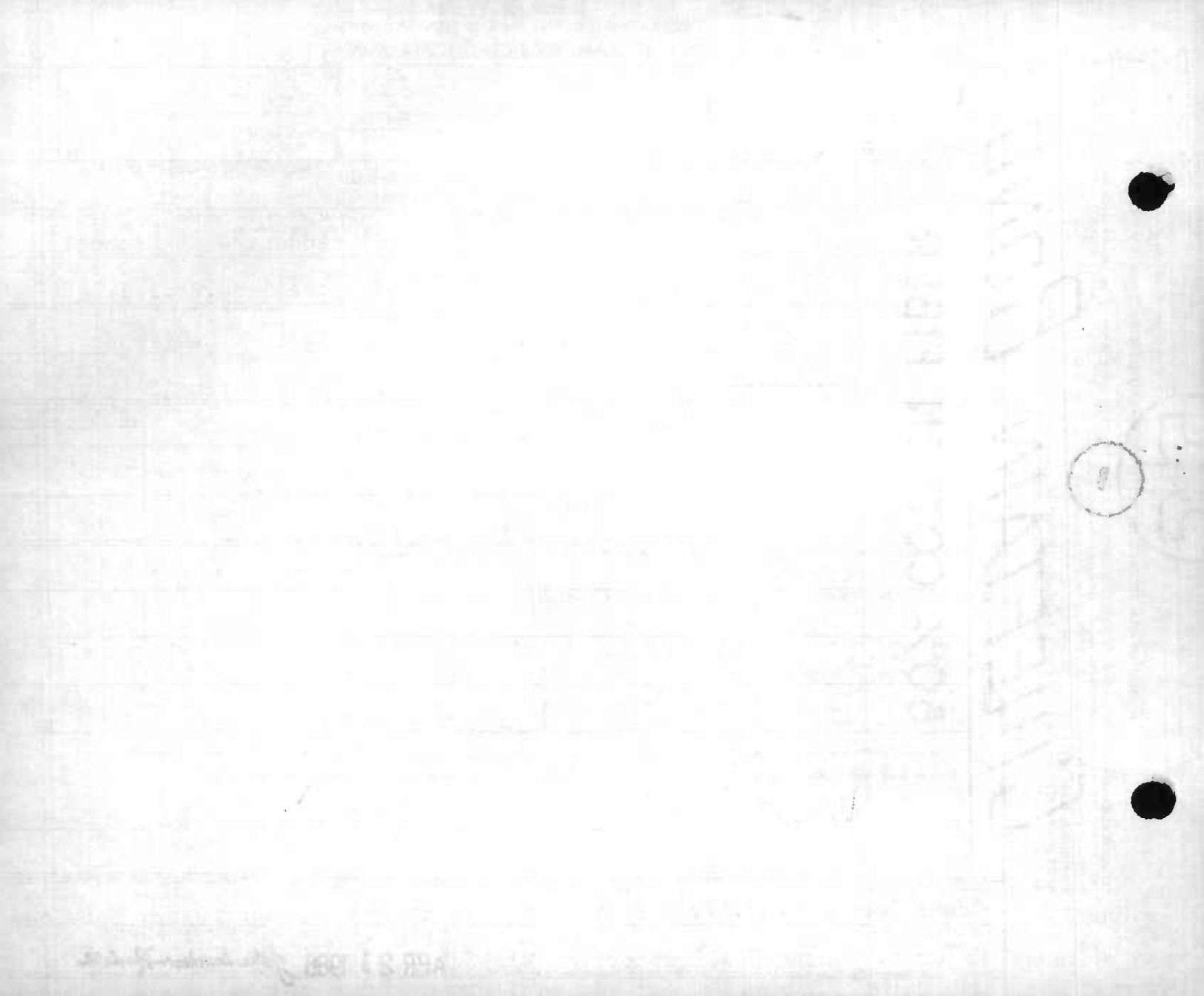
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (S))

FOR *Item 18a + 22a*
1- STATE REGISTRAR *7-17-86 CN* STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6 REG. NO. *2523*

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Hanna Hamilton Daniels</i>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>4/ 13/ 19 86</i>		2b. HOUR M <i>9:30 A M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 22, 64</i>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>21</i>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>4/ 15/ 19 86</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington County</i>		MD.			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>student</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>school</i>					
13. STATE <i>Maryland</i> 13b. COUNTY <i>Washington</i> 13c. CITY OR TOWN <i>Hagerstown</i>					
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>Hopewell Rd. Rt. 1 21740</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Peter Moller Daniels, Sr.</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Linda Sanz Hamilton</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-82-4605</i>		17. INFORMANT ADDRESS <i>Peter M. Daniels (item 13 above)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>COCAINE Intoxication</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8:30 PM 4/15/1986</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Subject overdosed on drug</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Garage</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>610 N Prospect St Hagerstown md</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) M.D. <i>Assistant</i> MEDICAL EXAMINER		DATE SIGNED <i>4/15/86</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Margarita A. Korell, M.D.</i>		ADDRESS <i>111 Penn St.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Apr. 17, 86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Smithsburg Crematory</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Smithsburg Wash. Maryland</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>Major M. Osborne Williamsport, MD 21795</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 21 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rendall</i>	

BP/113



00-04825

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 5 2 4
REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Harriet A DAVIS			7a DATE OF DEATH MONTH DAY YEAR April 19 1986		7b HOUR 10³⁰ PM
3 SEX female	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR January 13, 1892	6 AGE (IN YEARS LAST BIRTHDAY) 94 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
10 CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahrney Kerdy Mem- Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sales	12b. KIND OF BUSINESS OR INDUSTRY dept. store	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 525 N. Mulberry 21740	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Artz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Hines		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 323 10 4018		17. INFORMANT ADDRESS Mrs. Florence Harper, Hagerstown, Md.	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Organic Brain Syndrome**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
27b. SIGNATURE A. Wakeed, MD	DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-20-86
27d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAKEED, MD	27e. ADDRESS 1610 - OAK HILL AVE. HAGERSTOWN, MD 21740		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Apr. 23, 1986	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland
24. FUNERAL DIRECTOR NAME MINNIE FUNERAL HOME		25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 23 1986	
415 E. Wilson Blvd., Hagerstown, Md. 21740			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

23810-10

2000 1001 PL 100A 2000 1001 PL 100A

0-03334

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE FLORENCE EDITH EISSNER CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
2a DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Florence Edith Eissner						4 / 4 / 86		6 40 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7b IF UNDER 1 YEAR MONTHS DAYS	
Female		White		7- 18 1900		85		YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		U.S.A.				Washington County MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Hagerstown		Colton Villa Nursing Center							
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
Housewife									
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE	
Maryland		Washington		Hagerstown				50 Summit Avenue 21740	
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Alvey Worthington				Mary Catherine Womax					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS			
No				- - - 217-12-1666		Earl W. Eissner 8 Brightwood Drive Hagerstown, Md. 21740			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE Cause (a) <u>ADENOCARCINOMA FRONTAL BONE ORBITAL CELLULITIS</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 19 86, to 19 86, that (I) (we) last saw the deceased alive on 4/4/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE				DEGREE				22c DATE SIGNED	
Th Hoachlander				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				4/5/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS					
ELDON HOACHLANDER				HAGERSTOWN MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		4-7-86		Rose Hill Cemetery		Hagerstown, Washington, Md.			
24 FUNERAL DIRECTOR NAME				25a DATE RECEIVED BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
A.K. Coffman Funeral Home, Inc.				APR 11 1986		John Davidson-Harrell			

FLORIAN NORTH KISSING

1/2 1/2 1/2 1/2

White

West Virginia

Washington County

Hagerstown Colton Villa Nursing Center Houserville

Marlene Washington Hagerstown X 30 Summit Avenue 21740

Alvey Washington

Catherine

8 Brightwood Drive

217-10-1000 Hagerstown, Md. 21740



Burial

4-7-88

Rose Hill Cemetery Hagerstown, Washington, Md.

Hagerstown, Md.

A. M. Colman Funeral Home, Inc.

00-052081

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 2 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nellie Virginia Elwell			2a. DATE OF DEATH MONTH DAY YEAR April 21, 1986		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 10, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Williamsport	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Golden Staley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Mary Chrisman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 215-20-9243		17. INFORMANT ADDRESS Gary L. Monnonger Rt. 2 Williamsport, MD 21795	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE/CHRONIC RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and I) did not view the body after death.					
22b. SIGNATURE <u>C. D. WICKSTER</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C D WICKSTER		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 24, 86	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Memorial Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington Maryland
24. FUNERAL DIRECTOR NAME Major M. Osborne			25a. DATE REC'D. BY REGISTRAR APR 30 1986		
ADDRESS Williamsport, MD 21795			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

BP _____

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked as item 18 about any injury, or other traumatic event, the medical examiner must be notified at once.

00-02300

20% COTTON FIBER

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00-05495

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 12527
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK		FIRST		MIDDLE		LAST		20. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
						ENYART		April 28 86		3 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 26, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Knitting Mill	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Fred.		13c. CITY OR TOWN Sabillasville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14716 Foxville-Deerfield Rd. 21780			
14. FATHER'S NAME FIRST MIDDLE LAST Virgil - Enyart		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth - Moore									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 415-16-0040		17. INFORMANT ADDRESS Mrs. Dorothy M. Enyart, Sabillasville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic adenocarcinoma of prostate gland											
DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION 6-17-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Urinary neoplasm				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 6-15 , 19 85 , to 4-28 , 19 86 , that (1) (we) last saw the deceased alive on 4-28 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.											
22b. SIGNATURE William H. Plavcan		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-28-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WM. G. PLAVCAN				22e. ADDRESS 1198 KENLY AVE, HAGERSTOWN, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 1, 1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery				23d. LOCATION Foxville, Fred., Md. STATE			
24. FUNERAL DIRECTOR NAME Dennis L. Davis				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Dennis L. Davis				21783				MAY 02 1986			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

MAY 02 1986

1. The first part of the document is a letter from the Director of the Federal Bureau of Investigation to the Director of the Central Intelligence Agency. The letter is dated 10/10/50 and is addressed to the Director of the Central Intelligence Agency, Washington, D.C.

2. The second part of the document is a letter from the Director of the Federal Bureau of Investigation to the Director of the Central Intelligence Agency. The letter is dated 10/10/50 and is addressed to the Director of the Central Intelligence Agency, Washington, D.C.

3. The third part of the document is a letter from the Director of the Federal Bureau of Investigation to the Director of the Central Intelligence Agency. The letter is dated 10/10/50 and is addressed to the Director of the Central Intelligence Agency, Washington, D.C.

4. The fourth part of the document is a letter from the Director of the Federal Bureau of Investigation to the Director of the Central Intelligence Agency. The letter is dated 10/10/50 and is addressed to the Director of the Central Intelligence Agency, Washington, D.C.

5. The fifth part of the document is a letter from the Director of the Federal Bureau of Investigation to the Director of the Central Intelligence Agency. The letter is dated 10/10/50 and is addressed to the Director of the Central Intelligence Agency, Washington, D.C.

6. The sixth part of the document is a letter from the Director of the Federal Bureau of Investigation to the Director of the Central Intelligence Agency. The letter is dated 10/10/50 and is addressed to the Director of the Central Intelligence Agency, Washington, D.C.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified.

00-04208

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 2 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dale Leon FEARNOW			2a. DATE OF DEATH MONTH DAY YEAR April 18, 1986			2b. HOUR 6:30 ^a _M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 12, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.				
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12 N. Clifton Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent		12b. KIND OF BUSINESS OR INDUSTRY Insurance		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Leona Curtis Fearnow					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Estella Myers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW II 215-09-7403		17. INFORMANT ADDRESS Kathryn M. Fearnow (item 13 above)					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma Lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>?</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>none</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (XXXXX) attended the deceased from <u>Sept. 8, 1984</u> to <u>April 18, 1986</u> , that (I) (X) last saw the deceased alive on <u>April 7, 1986</u> , and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (XX) did (did not) view the body after death.										
22b. SIGNATURE <u>Max E. Byrkit</u> DEGREE M.D.						22c. DATE SIGNED April 18, 1986		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Max E. Byrkit, M.D.		
22e. ADDRESS 28 West Potomac Street Williamsport, Maryland 21795										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 21, 86		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington Maryland			
24. FUNERAL DIRECTOR NAME Major M. Osborne						25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		
ADDRESS Williamsport, MD 21795										



CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

00-04639

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12529
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
		RUSSELL		GARY		April		13		8p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		MONTH DAY YEAR 6 16 39		46 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MORRISTOWN N.J.		U.S.A.				WASHINGTON CO				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
AGERSTOWN		WASH. CO. HOSPITAL		Custodian		School					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE							
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE							
PENNA		FRANKLIN		FT. LOUDON		264 BEAR VALLEY RD.		99999			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
ROBERT J. GARY		RACHAEL HOFFMAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
		135-30-5864		BETTY GARY		264 BEAR VALLEY RD. FT. LOUDON PA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:											
<u>cachexia secondary to malignancy</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (I) (the hospital) attended the deceased from <u>4/13</u> 19 <u>86</u> , to <u>4/13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/13</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
<u>George Newman II M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		4/13/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
BURIAL		4/18/86		ST. THOMAS CEM.		ST. THOMAS		FRANKLIN		PA	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME ADDRESS				APR 22 1986							
R.G. SELLERS F.A. INC 297 PHILA. AVE CHAMBG. PA											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]



WLB: [illegible]

00-03923

1- FOR
STATE
REGISTRAR

Rhoda Gray

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 3 0
REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Rhoda Earlena Gray				4 13 86		8:45 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Female	white	3 13 03		83 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA			Washington MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Colton Villa Nursing Home					bread	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. STREET ADDRESS / ZIP CODE			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				521 N. Mulberry Street 21740			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Otho W. Gray				Dulcia Reel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
no		214-09-7639A		William Ewing, Abbington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Abdul Waheed, M.D.		M.D.				4-14-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
		1610 Oak Hill Avenue Hagerstown, MD 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
burial		Apr. 16, 1986		Rest Haven Cem.		Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS				25. RECEIVED BY REGISTRAR REGISTRAR'S SIGNATURE			
415 E. Wilson Blvd., Hagerstown, Md. 21740				APR 16 1986 John Gordon			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

00-0233

20% COTTON FIBER



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Adelia "May" GREINER					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR April 12 1986 2:00 PM				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 7 1891		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washingt. Co. MD.			
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Henry Clopper					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Margaret Koberstine				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-9793		17. INFORMANT ADDRESS Priscilla C. Greiner same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive pulmonary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Chronic obstructive pulmonary disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>10/9</u> 19 <u>84</u> , to <u>4/12</u> 19 <u>86</u> , and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4/14/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Allen D. H. MD</u>				22e. ADDRESS <u>1610 Oak Hill Ave Hagerstown MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-15-86		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.			
24. FUNERAL DIRECTOR NAME Gerald N. Minnich				ADDRESS 305 N. Potomac St. Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



Handwritten notes and signatures at the bottom of the page, including the date 'APR 22 1945' and various illegible signatures and markings.

00-03741

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

1 2 5 3 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Jacob Markwood Hines</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 10 86</i>			2b. HOUR <i>11 45 AM</i>					
3. SEX <i>m</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 2 1911</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74 YRS.</i>		IF UNDER 1 YEAR MONTHS DAYS <i>5 8</i>		IF UNDER 24 HRS. HOURS MIN. <i>11 45</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>U.S.A.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Railroad</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Md.</i>				13b. COUNTY <i>Wash.</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1809 Burnside Ave. 21740</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph H. Hines</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary A. Kretzer</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>214-09-2796</i>		17. INFORMANT ADDRESS <i>Elizabeth V. Hines, Hagerstown, Md.</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*8 months*PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *no*

MEDICAL CERTIFICATION

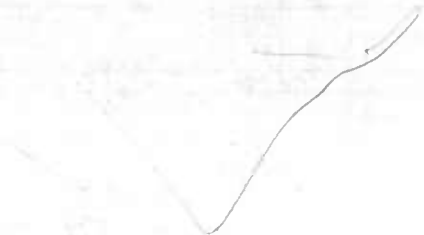
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>March 19 19 86</i> to <i>April 10 19 86</i> that (1) (we) lost saw the deceased give on <i>4/10</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Robert Bull</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <i>April 14 1986</i>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Bull</i>		22d. ADDRESS <i>1459 Potomac Ave Hagerstown</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>April 14, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</i>				25a. DATE RECD. BY REGISTRAR <i>4/15/86</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified of this.



0-04502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 5 3 3
REG. NO.

1- FOR STATE REGISTRAR **Mary Amanda Hoffman**

1 DECEASED NAME (TYPE OR PRINT) Mary Amanda Hoffman		2a. DATE OF DEATH MONTH DAY YEAR April 19, 1986		2b. HOUR 6⁴⁰ P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 5, 1888	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 97 YRS MONTHS DAYS	
10 CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahmy - Keedy Memorial Home		9 BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store		13a. STREET ADDRESS / ZIP CODE Route # 2 Box 334 21740	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Franklin Pry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Amanda Grayson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 578-12-2613		17. INFORMANT Louise V. Pry		17a. ADDRESS Route # 2 Boonsboro, Md. 21713	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Cardiac arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Congestive heart failure**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **0**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Ornel		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-21-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAHEED, MD				22e. ADDRESS 1610 - OAK HILL AVE. HAGERSTOWN, MD 21740			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-22-86		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sharpsburg, Washington, Md.	
24 FUNERAL DIRECTOR NAME Andrew K. Coffman Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR APR 23 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 102 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

00-02851

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12534
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Roy Jones, Sr.				2a. DATE OF DEATH MONTH DAY YEAR 4-5-86				2b. HOUR 355 M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01-25-12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON, MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HANCOCK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE ROUTE #2 21750	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY SHADRIC JONES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIA ANN EDWARDS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW II 440 14 1403		17. INFORMANT ADDRESS SANDRA L. HOWARD 220 WEST HIGH STREET HANCOCK, MD. 21750			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pancreatic cancer w/ liver metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Dehydration</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
27a. SIGNATURE Laurence Green's Pool				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-5-86	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) LAURENCE GREEN'S POOL				22e. ADDRESS 130 W. HIGH ST. - HANCOCK, MD 21750					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/8/1986		23c. NAME OF CEMETERY OR CREMATORY ST. THOMAS EPISCOPAL		23d. LOCATION CITY OR TOWN COUNTY STATE HANCOCK WASHINGTON, MD.			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE APR 08 1986 Julia Davidson-Randall			

BP
DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

RECEIVED

NOV 20 1964



00-03112

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate pages 1 and 2 and file with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8612535	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) JANET M. KLEPPINGER					2a. DATE OF DEATH MONTH DAY YEAR 4 5 86				2b. HOUR 3 AM		
3. SEX F		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 11 10 1919		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Worker		12b. KIND OF BUSINESS OR INDUSTRY Aircraft Mfg.		
13a. STATE Md.					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Baumgardner					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Kuhn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 160-16-8622			17. INFORMANT Hagerstown, Md. 21740 Rd. Mr. John I. Kleppinger 43 W. Long Meadow					
18. CAUSE OF DEATH (Enter only one cause per line. Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO OR AS A CONSEQUENCE OF State Myocardial Infarction											
DUE TO OR AS A CONSEQUENCE OF Chronic Coronary Artery Disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe Obesity, COPD											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/5 19 86, to 4/5 19 86, that (I) (we) last saw the deceased alive on 4/5 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Francis L. Andrade						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCISCO L. ANDRADE M.D.						22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/7/86		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro Franklin Pa.			
24. FUNERAL DIRECTOR NAME John J. Lane						ADDRESS 50 S. Broad St. Waynesboro, Pa.		25a. DATE REC'D. BY REGISTRAR APR 9 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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0-05479

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 8 1 2 5 3 6
REG. NO.

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Amanda Rae KLINE

2a. DATE OF DEATH MONTH DAY YEAR
04 25 86

2b. HOUR
4:30 P.M.

3. SEX
Female

4. RACE
White

5. DATE OF BIRTH MONTH DAY YEAR
01 13 1911

6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
75 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Washington MD.

10. CITY OR TOWN OF DEATH
Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington County Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife

12b. KIND OF BUSINESS OR INDUSTRY
Home

13a. STREET ADDRESS / ZIP CODE
Rt. 113823 John Kline Rd. 21783

13b. CITY OR TOWN
Smithsburg

13c. COUNTY
Frederick

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

14. FATHER'S NAME FIRST MIDDLE LAST
John W. Brandenburg

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ada Alice Harshman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no

16b. SOCIAL SECURITY NO.
214-32-4614

17. INFORMANT ADDRESS
Mrs. Joyce K. Grove, Smithsburg, Md., 21783

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiac arrest

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE

22c. DATE SIGNED
4/25/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ABDUL WAHEED MD

22e. ADDRESS
1610 - OAKHILL AVE. HAG, MD 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
Apr. 29, 1986

23c. NAME OF CEMETERY OR CREMATORY
St. Mark's Lutheran Cem.

23d. LOCATION CITY OR TOWN COUNTY STATE
Wolfsville, Fred., Md.

24. FUNERAL DIRECTOR NAME
Davis Funeral Home, Smithsburg, Md., 21783

25a. DATE REC'D. BY REGISTRAR
MAY 01 1986

25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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00-05498

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8612537

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Gladys Louise Laupert		4 19 86		5:10 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	Caucasian	11 6 1900	85	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Washington MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Washington County Hospital		Housewife	Home	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	Box 84
Md.	Wash.	Williamsport		2414 Franklin Ave. Rt. 2, 21795	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Elmer - Anthony		Maude - Troxell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		705-10-4754A		Mr. Adam F. Laupert, Williamsport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bone Metastases DUE TO, OR AS A CONSEQUENCE OF (b) Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YRS. 4 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/28 19 86, to 4/19 19 86, that (I) (we) last saw the deceased alive on 4/18 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.					
22b. SIGNATURE Charles R. Chaney M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/19/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles R. Chaney M.D.		22e. ADDRESS 363. S. Cleveland Ave. Hagerstown Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Cremation	Apr. 19, 1986	Smithsburg Crematory	Smithsburg, Wash., Md.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Jimmie L. Davis Davis Funeral Home, Smithsburg, Md., 21783		MAY 01 1986		Gubert...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12538
REG. NO.

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		FIRST MIDDLE LAST ANNA Idella LEITER		MONTH DAY YEAR April 11 86		105 PM	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1715 Fountain Head Road 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel A. Munn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Bradford Houston		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-74-9658	
17. INFORMANT ADDRESS Mrs. Phyllis Heatwole, Pittsburg, PA.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Bed ridden state</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senile Dementia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years 3 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic Coronary Vessel Disease with Congestive Heart Failure</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if this hospital) attended the deceased from above, (if we did) (if not) view the body after death.		4/10 19 86, to 4/11 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE Robert Brull		22c. DATE SIGNED 4/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 1459 Potomac Ave. Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740		25a. DATE REC'D. BY REGISTRAR APR 16 1986		25b. REGISTRAR'S SIGNATURE Jillie K. Wilson-Randall			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 2 5 3 9

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Hazel A. Long			2a. DATE OF DEATH MONTH DAY YEAR 4 2 86			2b. HOUR 2 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Keedysville, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT RESIDENT, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE WORK FOR LAST 12 MONTHS OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rfd. 2 Box 78 21713	
14. FATHER'S NAME FIRST MIDDLE LAST D. Frank Miller					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Downey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-46-8706		17. INFORMANT ADDRESS Bast Funeral Home Records, Boonsboro, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Acute Onigoria DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) - Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF } (c) - Arteriosclerotic Heart Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
								yes	
								yes	
								yes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 3-27 , 19 86 , to 4-2 , 19 86 , that (I) (we) last saw the deceased alive on 4-1 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.									
22b. SIGNATURE John Hornbaker, Jr. M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-2-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Hornbaker, Jr. M. D.					22e. ADDRESS 645 E. First St., Hagerstown, Md. 21740				
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 4-5-86		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash. Co., Md.		
24. FUNERAL DIRECTOR NAME ADDRESS John H. Bast, Jr. Boonsboro, Md. 21713					25a. DATE REC'D. BY REGISTRAR APR 08 1986		25b. REGISTRAR'S SIGNATURE John H. Bast, Jr.		

MEDICAL CERTIFICATION

0-04822

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6										REG. NO. 1 2 5 4 0	
1. DECEASED NAME (TYPE OR PRINT) Oliver Norwood LONG							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> APR 18 1986		2b. HOUR 4:55 P.M.		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR April 1, 1912		6. AGE (IN YEARS) LAST BIRTHDAY 74RS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD APR 18 1986		2d. HOUR 4:55 M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) electrician		12b. KIND OF BUSINESS OR INDUSTRY electric Co.			
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 85 Nottingham Road	
14. FATHER'S NAME FIRST MIDDLE LAST Clayton Long				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Dermer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. W.W. II 214-07-2827		17. INFORMANT ADDRESS Mrs. Helen Long, Hagerstown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE H. N. Weeks				TITLE (SPECIFY) Dep M.D. MEDICAL EXAMINER				DATE SIGNED Apr 18 86			
EXAMINER'S NAME (TYPE OR PRINT) H. N. WEEKS				ADDRESS 580 North Ave Hagerstown Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr 21, 1986		23c. NAME OF CEMETERY OR CREMATORY Indian Mound Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Romney, West Virginia			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR APR 23 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			
415 E. Wilson Blvd., Hagerstown, Maryland 21740											

20% COTTON FIBER

MADE IN U.S.A.



00-04630

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

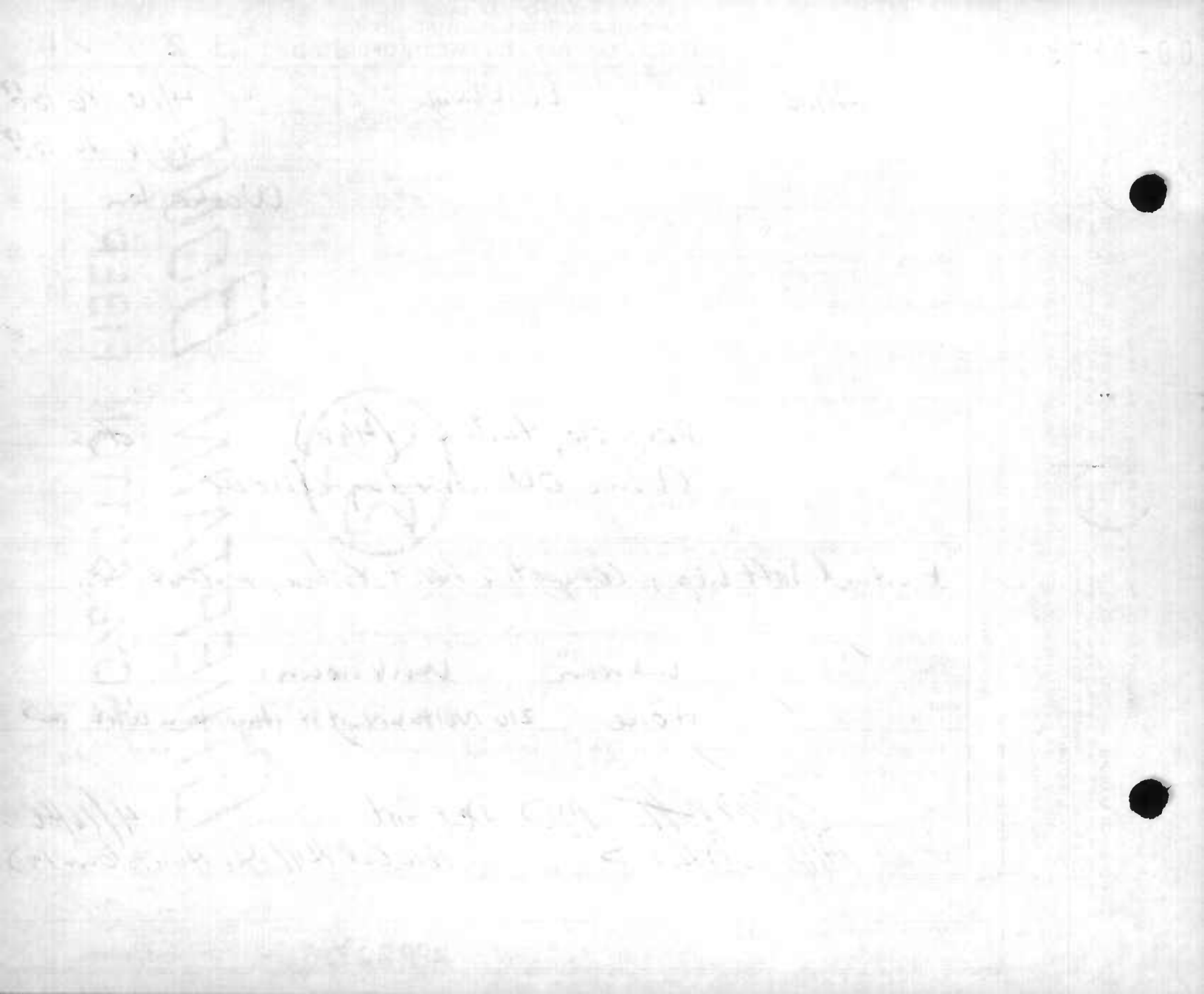
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12541

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Alma L. Lushbaugh				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4/16 1986				2b. HOUR 12 PM					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 30, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4/16 1986		2d. HOUR 12 PM			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk				12b. KIND OF BUSINESS OR INDUSTRY aircraft	
13a. STATE Maryland				13b. CITY OR TOWN Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 216 N. Locust St. 21740			
14. FATHER'S NAME FIRST MIDDLE LAST B. Frank Lushbaugh						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Baker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-2785				17. INFORMANT ADDRESS Lena M. Allen, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure (496) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic obstructive lung disease. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Fractured left hip, congestive heart failure, malnutrition													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. unknown				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) unknown					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 216 North Locust St Hagerstown Wash MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Allen W. D. H. MD				TITLE (SPECIFY) MD Det. Asst				DATE SIGNED 4/16/86					
EXAMINER'S NAME (TYPE OR PRINT) Allen W. D. H. MD				ADDRESS 1610 Oak Hill Dr Hagerstown MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE Apr. 19, 1986		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR APR 22 1986							
415 E. Wilson Blvd., Hagerstown, Md. 21740						25b. REGISTRAR'S SIGNATURE John Switzer-Pondell							



00-03632

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 6 1 2 5 4 2				
1. DECEASED NAME (TYPE OR PRINT)					REG. NO.				
FIRST MIDDLE LAST ELSIE TOUCHTON MC ALLISTER					2a. DATE OF DEATH MONTH DAY YEAR April 10, 1986				
3. SEX Female					2b. HOUR 7:00p M				
4. RACE White					6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.				
5. DATE OF BIRTH MONTH DAY YEAR Oct. 29, 1902					7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.				
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland					9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD				
7b. CITIZEN OF WHAT COUNTRY? U.S.A.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12 South Walnut Street					12b. KIND OF BUSINESS OR INDUSTRY				
10. CITY OR TOWN OF DEATH Hagerstown					13a. STREET ADDRESS 12 South Walnut Street				
13a. STATE Maryland					13b. COUNTY Washington				
13c. CITY OR TOWN Hagerstown					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Edgar Evan Touchton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Etta Grason				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 220-30-9467				
17. INFORMANT Thomas J. Mc Allister Hagerstown, Md.					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Systolic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized atherosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cardiac arrest Apr 1986 persistent chronic obstructive pulmonary disease</u>				
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21e. LOCATION STREET CITY OR TOWN COUNTY STATE					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 11</u> , 19 <u>26</u> , to <u>April 10</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>April 10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					22b. SIGNATURE DEGREE <u>LL Packer Jr MD</u>				
22c. DATE SIGNED <u>4/11/86</u>					22d. ADDRESS <u>145 W. Washington St Hagerstown, MD 21740</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					23b. DATE 4-12-86				
23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematorium Smithsburg, Wash., Md.					23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.					25a. DATE REC'D. BY REGISTRAR APR 15 1986				
25b. REGISTRAR'S SIGNATURE <u>Walter R. Randle</u>									

Female	White	Oct. 29, 1902	23	Washington County
Maryland	U.S.A.	X		
Hagerstown	12 South Walnut Street			Houswife
Maryland	Washington Hagerstown			12 South Walnut Street
Age	Known	Township	Wife	Grason
no	- - -	23-10-1902	Thomas J. Mc Allister	Hagerstown Md.

00-04730

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 5 4 3
REG. NO.

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES R Mc DONALD		2a DATE OF DEATH MONTH DAY YEAR April 19, 1986		2b HOUR 2:25 PM	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR May 2, 1926		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE MD.				13b CITY OR TOWN Rockville		13c STREET ADDRESS / ZIP CODE 721 Lenmore Ave. - 20850	
14 FATHER'S NAME FIRST MIDDLE LAST Herbert Sewell				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie JOHNSON			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 218-24-0436		17 INFORMANT ADDRESS Terry Roseby 110 Stonegate Dr. Frederick, MD 21701			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) As hypertensive CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus CHF by history APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months years years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: na							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/18/86 to 4/19/86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/19/86 , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If <input type="checkbox"/> (did) not see the body after death, <input type="checkbox"/> (xxx))							
22b SIGNATURE MILANINIA				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/19/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MILANINIA				22e ADDRESS 1500 Pa Am Hagerstown rd			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-24-86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. MD	
24 FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Washington Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR APR 24 1986	
				25b. REGISTRAR'S SIGNATURE J. A. [Signature]			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a certifying physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please return page 3 to the funeral director. Pages 1 and 2 should be filed with the health department within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, secondary injury, or other traumatic event, the medical examiner must be notified at once.

CONFIDENTIAL - R The Director, FBI, Washington, D.C.

Re: [illegible]

[illegible]

[illegible]

[illegible]

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00-05478

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 4 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Harold McKinsey			2a. DATE OF DEATH MONTH DAY YEAR April 16, 1986		2b. HOUR 6:10 ^{PM}
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 10, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2416 Paradise Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman	12b. KIND OF BUSINESS OR INDUSTRY Pangborn	
13a. STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2416 Paradise Drive 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Hiram J. McKinsey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Warbel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no -		16b. SOCIAL SECURITY NO. 214-09-6647		17. INFORMANT ADDRESS Mrs. Jane E. McKinsey, Hagerstown, Md., 21740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe Parkinson's Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>Jan 11, 1980</u> to <u>April 16, 1986</u> , that (2) (we) last saw the deceased alive on <u>April 14, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)					
22b. SIGNATURE <u>[Signature]</u>		DEGREE MD		22c. DATE SIGNED 4/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull		22e. ADDRESS 1459 Potomac Ave Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 19, 1986		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Wash. Md.		24. FUNERAL DIRECTOR NAME <u>Dennis L. Davis</u> ADDRESS <u>[Address]</u> Davis Funeral Home, Smithsburg, Md., 21783			
25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE MAY 01 1986 <u>[Signature]</u>					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8612545

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		Lester Metcalf MENTZER Sr.		April 25, 1986		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))	
male		white		October 24, 1898		87	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Washington MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital		sheet metal		aircraft	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
Carlton C. Mentzer		Annie E. Metcalf		1146 Luther Drive 21740			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
No		219 07 1955		Mary K. Mentzer, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
						4-25-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
62. B. KONG, M.D.				1933 Va. Ave. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
burial		Apr. 28, 1986		Greenlawn Mem. Park		Williamsport, Wash., Maryland	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				APR 29 1986		Julia Davidson-Rodarte	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

CONFIDENTIAL



APR 28 1968

0-03943

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HOWARD THOMAS MILLER			2a. DATE OF DEATH MONTH DAY YEAR APRIL 9, 1986			2b. HOUR 1:15 A.M.			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 29 1931		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 1 15 A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fork Lift Opertr		12b. KIND OF BUSINESS OR INDUSTRY Auto	
13a. STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Myersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Roscoe L Miller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret A Gaver			16. STREET ADDRESS 12227 Harp Hill Road 21773			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 214-34-0644		17. INFORMANT Ruth L. Miller		18. ADDRESS 12227 Harp Hill Road Myersville, MD 21773		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED. 5 - 10 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) XXXXXX attended the deceased from DECEMBER 10 19 76 to APRIL 9 19 86 , that (1) (X) last saw the deceased alive on JANUARY 7 19 86 , and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above; (2) (X) did not view the body after death.									
22b. SIGNATURE <i>Edward W. Ditto III</i>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED APRIL 9, 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.			22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 11, 1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion U.M. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Myersville Frederick Maryland		
24. FUNERAL DIRECTOR <i>Ricketts</i> Ricketts Funeral Home					ADDRESS Myersville, MD 21773		25. DATE REC'D. BY REGISTRAR APR 10 1986		
					25b. REGISTRAR'S SIGNATURE <i>John L. ...</i>				

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12547

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Audrey Anna Monninger			2a. DATE OF DEATH MONTH DAY YEAR April 13, 1986			2b. HOUR M M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 2, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 71		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route # 4 Box 231				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route # 4 Box 231	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Durboraw			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva Robison			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 214-09-9901			17. INFORMANT Earl M. Dofflemeyer			ADDRESS Route # 4 Box 231 Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PLEURAL EFFUSION DUE TO, OR AS A CONSEQUENCE OF (c) BREAST CANCER METASTASIS TO PLEURA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ARTEIOSCLEROSIS, DIABETES MELLITUS, CONGESTIVE HEART FAILURE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10/17 , 19 84 , to 4/13 , 19 86 , that (I) (we) lost saw the deceased alive on MARCH 20 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (we) (I) (did not) view the body after death.									22b. SIGNATURE Stephen E. Metzner M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 4/15/86			22d. ADDRESS 1825 HOWELL RD, HAGERSTOWN, MD.			22e. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN E. METZNER, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-16-86			23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park Hagerstown Washington, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.			25a. DATE DECEASED BY DEATH APR 18 1986			25b. REGISTRAR'S SIGNATURE			25c. DATE SIGNED	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on after death.

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Route # 4 Box 131

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Hodgkinson, J.C.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 4 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Jack E. Eugene Moore</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4-26-86</i>		2b. HOUR <i>5:35 PM</i>								
3. SEX <i>male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6 9 30</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>55</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington County</i> MD.							
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>manager</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>office supply</i>					
13a. STATE <i>Maryland</i>						13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>313 S. Potomac St. 21740</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Moore</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mabel Cornwell</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-22-8452</i>			17. INFORMANT ADDRESS <i>Colleen Levey, Hagerstown, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestive cardiomyopathy</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one hour</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a													
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>4/26</i> , 19 <i>86</i> , to <i>4/26</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>4/26</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Gloria F. Pura</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4/27/86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GLORIA F. PURA</i>						22e. ADDRESS <i>339 E. Antietam St. Hagerstown</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>			23b. DATE <i>Apr. 30, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>						
24. FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</i>						25. DATE OF DEATH <i>APR 30 1986</i>		25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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ATTORNEY GENERAL
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death ~~of~~ be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be submitted to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86
REG. NO.

1 2 5 4 9

1. DECEASED NAME (TYPE OR PRINT)		FIRST DOROTHY		MIDDLE ANN	LAST MORROW		20. DATE OF DEATH MONTH DAY YEAR 1/2/1986		2b. HOUR 10:30 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4/30/1932		6. AGE (IN YEARS (LAST BIRTHDAY)) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Waynesboro, PA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. Hagerstown, MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) bar maid		12b. KIND OF BUSINESS OR INDUSTRY tavern			
13a. STATE MD						13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James W. Morrow						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Baker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 208-24-4716		17. INFORMANT ADDRESS 17250 Mrs. Clarence Downin Box 118 Rouzerville, PA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few hours 8 yrs. 5 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M.B. Ojima						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-3-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Massoud B. Alizadeh MD						22e. ADDRESS 240 Frederick St Hagerstown, MD 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/1986		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro Franklin, PA					
24. FUNERAL DIRECTOR NAME David Y. [Signature]						Waynesboro, PA 17268		25a. DATE REC'D. BY REGISTRAR MAY 12 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR 04/10/86		2b HOUR 1:15 PM	
1 DECEASED NAME (TYPE OR PRINT) MABEL ELLEN MORT MORT		3 SEX FEMALE		4 RACE WHITE	
5 DATE OF BIRTH M 10/09/35 YEAR		6 AGE (IN YEARS LAST BIRTHDAY) 50		7a BIRTHPLACE (STATE OR FOREIGN) MARYLAND	
7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION WESTERN MD HOSPITAL CENTER Western Maryland Center		12a USUAL OCCUPATION HOUSEWIFE	
12b KIND OF BUSINESS OR OWN HOME		13 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD STATE FREDERICK KEYMAR TOWN		14 SIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
15 FATHER'S NAME IVAN W. MYERS		16 MOTHER'S MAIDEN NAME MARY ELLEN HAHN		17 ADDRESS 12432 RENNER RD. 21757	
18a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b SOCIAL SECURITY NO. 213-40-2410		17 INFORMANT FRANKLIN E. MORT	
18c CAUSE OF DEATH (Enter only one cause per part 1, (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissection Multifome</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>month</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION <u>3/21/86</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain tumor</u>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2/7/86</u> , 19 <u>86</u> to <u>4/10</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4/10</u> , 19 <u>86</u> , and that in (my) xxx opinion death occurred on the date and hour and from the causes stated above. (I) xxx (did not) view the body after death.					
22b SIGNATURE <u>Rose Marie Chan, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <u>4/10/86</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROSE MARIE CHAN</u>		22e ADDRESS <u>Western Maryland Center Hagerstown MD 21740</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b DATE <u>04/13/86</u>		23c NAME OF CEMETERY OR CREMATORY <u>UNIONTOWN LUTHERAN CEME</u>	
23d LOCATION <u>UNIONTOWN CARROLL MD</u>		24 FUNERAL DIRECTOR NAME <u>D. D. HARTZLER</u>		25a DATE REC'D. BY REGISTRAR <u>APR 14 1986</u>	
25b REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

1

29

2

33

B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-04740

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 5 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gladys M. MOSSBURG			2a. DATE OF DEATH MONTH DAY YEAR April 12, 1986			2b. HOUR 1:50 PM			
3 SEX Female		4. RACE White		5. DATE OF BIRTH WITH DAY YEAR Oct. 8 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady		12b. KIND OF BUSINESS OR Clothing Store	
13a. STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Frederick A. Browning			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Mae Showe			16. STREET ADDRESS / ZIP CODE 800 Motter Ave. 21701			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-9700		17. INFORMANT ADDRESS Mr. Richard C. Boone, 219 W. B. St. Brunswick, Maryland 21716				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Total Systems failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer (Melanoma) DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION none			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. none 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) none		21f. LOCATION STREET CITY OR TOWN COUNTY STATE -				
22a. I certify that (I) (this hospital) attended the deceased from 2-13-86 , 19____, to 4-12-86 , 19____, that (I) (we) lost saw the deceased alive on 4-12-86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W.W. Lesh M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-12-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William W. Lesh M.D.					22e. ADDRESS 411 Division Avenue Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Fred. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Smith Keeney Basford P.A. Funeral Home 106 E. Church St., Fred. Md. 21701					DATE REC'D. BY REGISTRAR APR 24 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson		

MEDICAL CERTIFICATION

2
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician who certifies the cause of death be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages, Pages 1 and 2, should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

BP _____

Total Systems Failure
Metastatic Cancer (Melanoma)

William W. Leish M.D.	4-12-88	2-13-88	4-12-88	none	none	x
411 Division Avenue Haverstown, Pa.						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a death certificate

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

12552

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence Faye MULLENDORE			2a. DATE OF DEATH MONTH DAY YEAR April 10 1986		2b. HOUR 12.22 am	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1890		
6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 201 Calvert Terrace 21740				
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		
14. FATHER'S NAME FIRST MIDDLE LAST James A. McCartney		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Bushong				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-88-5173		17. INFORMANT ADDRESS Patricia M. Marshall 201 Calvert Terrace Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN STEM INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) LARGE MYOCELEBRAL BLEED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hemorrhage						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from July 11 1985 to March 13 1986 , that (I) (we) last saw the deceased alive on MARCH 13 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or) (we) (did) (give) (find) the body after death.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-12-86		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.		24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc. Hagerstown, Md.				
25a. DATE REC'D. BY REGISTRAR APR 15 1986		25b. REGISTRAR'S SIGNATURE Davidson-Randall				

BP

James	White	Sept. 18, 1890	32
Indiana	U.S.A.		Washington County
Williamport Homewood Retirement Center	Housewife		
2140			
201 Calvert Terrace			
James	A.	McCarthy	James
212-22-2177	Patricia M. McCarthy		201 Calvert Terrace
Washington, Md.			

James A. McCarthy
 201 Calvert Terrace
 Washington, Md.
 212-22-2177

Patricia M. McCarthy
 201 Calvert Terrace
 Washington, Md.
 212-22-2177

James A. McCarthy
 201 Calvert Terrace
 Washington, Md.
 212-22-2177

Patricia M. McCarthy
 201 Calvert Terrace
 Washington, Md.
 212-22-2177

0-03631

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 5 5 3

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) STELLA Anna MURRAY			2a. DATE OF DEATH MONTH DAY YEAR APRIL 8, 1986		2b. HOUR 3:45 P M								
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 23, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		10. CITIZEN OF WHAT COUNTRY? United States		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.							
13. CITY OR TOWN OF DEATH Big Pool		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 1 Box 86				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		16. KIND OF BUSINESS OR INDUSTRY					
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland						17b. COUNTY Washington		17c. CITY OR TOWN Big Pool		17d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17e. STREET ADDRESS Route # 1 Box 86 21711	
18. FATHER'S NAME FIRST MIDDLE LAST Dallas Miller						19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Mills							
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				21. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 16 1187		22. INFORMANT ADDRESS Dorothy L. Trammell same as 13							
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MALNUTRITION										1 YEAR			
(c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): MULTIPLE ULCERATED DECUBITUS OVER BACK AND SACRUM													
24. DATE OF OPERATION				25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				33. LOCATION STREET CITY OR TOWN COUNTY STATE					
34. I certify that (1) XXXXXX attended the deceased from MAY 8 , 19 84 , to FEBRUARY 10 , 19 86 , that (1) XX last saw the deceased alive on FEBRUARY 10 , 19 86 , and that in (my) XX opinion death occurred on the date and hour and from the causes stated above. XX did not view the body after death.													
35. SIGNATURE <i>Edward W. Ditto</i>								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		36. DATE SIGNED APRIL 9, 1986			
37. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.								38. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740					
39. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				40. DATE 04/11/1986		41. NAME OF CEMETERY OR CREMATORY Parkhead Cemetery		42. LOCATION CITY OR TOWN COUNTY STATE Big Pool, Washington, Md.					
43. FUNERAL DIRECTOR NAME <i>Richard E. Hancok</i>								ADDRESS <i>MD</i>		44. DATE REC'D. BY REGISTRAR APR 15 1986		45. REGISTRAR'S SIGNATURE <i>Richard E. Hancok</i>	

BP

WASHINGTON

1 WEEK

ADDITIONAL

1 YEAR

ADDITIONAL

MULTIPLE ALLEGATIONS OF CRIMINAL ACTS AND VIOLATIONS

XXXXXX
FEBRUARY 1968
XX

THAT, NOTWITHSTANDING THE FACTS
OF THE MATTER, THE ALLEGATIONS

... ITT ...

00-02803

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 5 5 4
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (Type or Print) MILDRED V. Norris		2a. DATE OF DEATH MONTH DAY YEAR April 2nd 1986		2b. HOUR 1:40p.m.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 24, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Dress MFG.
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lewis Franklin Snyder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola May Davis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-12-0953		17. INFORMANT ADDRESS Charles E. Norris 215 Crest Avenue Hadden Hgts. N.J.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Carcinoma colon**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 81 , 19 81 , to April 2 , 19 86 , that (I) (we) last saw the deceased alive on April 1st 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			

22b. SIGNATURE F. Pura	DEGREE MD.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/2/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLOKIA F. PURA		22e. ADDRESS 339 E. Antietam ST. HAGERSTOWN	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-5-86	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown Wash. Md.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR APR 7 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

April 1942

100-23813



April 1942

100-23813

00-05596

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 5 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Louise Paden			2a. DATE OF DEATH MONTH DAY YEAR April 29, 1986			2b. HOUR 6:00 PM			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 10-16-11		6. AGE (IN YEARS LAST BIRTHDAY) 74		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 836 Guilford Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Plastics Mfg.	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 836 Guilford Ave. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Lloyd A. Haupt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angie M. Ford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-26-8286		17. INFORMANT ADDRESS 24 Wayside Ave. Mr. George A. Strausbaugh, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 5 min 10 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None									
19a. DATE OF OPERATION 9-7-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Myocardial infarction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3-10-86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) Myocardial infarction					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Williamsport Md. 21795					
22a. I certify that (I) (the hospital) attended the deceased from 9-7-86 to 4-27-86 , that (I) (we) lost saw the deceased alive on 3-10-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE ME Byrkit						DEGREE MD		22c. DATE SIGNED 4-30-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ME Byrkit						22e. ADDRESS Williamsport Md. 21795			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5-2-86		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS John H. Bast, Jr. Boonsboro, Md. 21713						25a. DATE REC'D. BY REGISTRAR MAY 5 1986		25b. REGISTRAR'S SIGNATURE John Davidson Handell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be retained until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-03740

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12556
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Angelo Leo Palladino		2a. DATE OF DEATH MONTH DAY YEAR 04-13-86		2b. HOUR 3:05 P.M.	
3. SEX Male		4. RACE White (1)		5. DATE OF BIRTH MONTH DAY YEAR 01 07 1906	
6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired accounting	
12b. KIND OF BUSINESS OR INDUSTRY railroad		13a. STREET ADDRESS / ZIP CODE 309 Liberty St. 21740		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lucca Palladino		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Walsh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 705-10-5605		17. INFORMANT ADDRESS Helen E. Palladino, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. yes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-13 , 19 86 , that (I) (we) last saw the deceased alive on 4-10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James L. Lucca		DEGREE MD		22c. DATE SIGNED 4-14-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		25a. DATE RECEIVED BY REGISTRAR APR 16 1986			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		25b. REGISTRAR'S SIGNATURE			
415 E. Wilson Blvd., Hagerstown, Maryland					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

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U.S. AIR FORCE

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Also this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item(s) show(s) any injury, or other traumatic event, the patient should be marked as order

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 2 5 5 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
PEARL		H. Price		4-17-86		11:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		white		7 12 95		90 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA		Washington MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		AVALON MANOR		cafe. manager		Bd. of Education			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Hebb Road 21740	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Freling H. Hoffmaster					L. Virginia Mikesell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no		213-12-7268		William R. Price, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
chr. and failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
W. B. Kang, M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				4-18-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
1933 S. Ave. Hagerstown, Md.				W. B. Kang, M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
burial		Apr. 20, 1986		Green Hill Cemetery		Waynesboro, Franklin, Penna.			
24. FUNERAL DIRECTOR'S NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
MYNNICH FUNERAL HOME				APR 23 1986		John Burton Anderson			
415 E. Wilson Blvd., Hagerstown, Md. 21740									

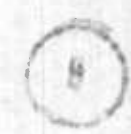
00-06266

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PARAGRAPH 18b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.
1. DECEASED NAME (TYPE OR PRINT) Angela D Denise Reilly												2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN 4 27 1986 8P³⁵M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR July 22, 1972	6. AGE (IN YEARS LAST BIRTHDAY) 13 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 27 1986 8P³⁵M	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		10. CITY OR TOWN OF DEATH Hagerstown		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE Maryland			13b. CITY OR TOWN Washington			
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 620 George Street 21740			14. FATHER'S NAME FIRST MIDDLE LAST Thomas Eugene Reilly			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Morris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 04 9000			17. INFORMANT Thomas E. Reilly, Hagerstown, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8169 IMMEDIATE CAUSE (a) Blunt force injuries to head N854 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Motor vehicle accident - ran off road E816 (c) Multiple traumatic injuries N869 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH seconds			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Multiple traumatic injuries N869												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 6:00 P.M. 4 27 1986			
21b. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:00 P.M. 4 27 1986			21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Car ran off road - hit bridge			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE Williamport Pike Franklin PA			22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			22b. ACTUAL SIGNATURE Allen D. H. MD M.D. TITLE (SPECIFY) Dist Asst			22c. DATE SIGNED 4/29/86			
22d. EXAMINER'S NAME (TYPE OR PRINT) Allen D. H. MD			22e. ADDRESS 1610 Oak Hill Ave Hagerstown MD			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE May 1, 1986			
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR MAY 9 8 1986			
25b. REGISTRAR'S SIGNATURE Julia L. ...			25c. ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740			25d. DATE REC'D. BY REGISTRAR MAY 9 8 1986			25e. REGISTRAR'S SIGNATURE Julia L. ...			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8012559

1. DECEASED NAME (TYPE OR PRINT) JAMES M. RICE		2a. DATE OF DEATH MONTH APRIL DAY 04 YEAR 1986		2b. HOUR 8 35 AM	
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH 02 DAY 04 YEAR 10		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION AVALLON MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OR NATURE OF WORKING LIFE) OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY HEAVY EQUIP
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD	13b. COUNTY FREDERICK	13c. CITY OR TOWN LIBERTYTOWN	13d. DOES CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS AND ZIP CODE 11927 MAIN ST. 21762	
14. FATHER'S NAME WILLIAM H. RICE, JR.			15. MOTHER'S MAIDEN NAME SERENA RYDER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 705-09-7575		17. INFORMANT MARTHA HENRY ADDRESS 84 LINCOLN APTS. FREDERICK, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer of prostate DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Mar 12 19 86 to Apr. 4 19 86 , that (I) (we) last saw the deceased alive on Apr. 4 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William W. Lesh MD				22c. DATE SIGNED 4-4-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William W. Lesh M.D.				22e. ADDRESS 411 Division Ave Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 04/06/86		23c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY CEMETERY	
23d. LOCATION (CITY OR TOWN) LIBERTYTOWN		23e. COUNTY FRED. MD			
24. FUNERAL DIRECTOR NAME D. D. HARTZLER ADDRESS LIBERTYTOWN, MD				25a. DATE REC'D. BY REGISTRAR APR 08 1986	
				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked, item 18 shows only injury, or other traumatic event, the medical examiner must file the medical report.

12

Metastatic Cancer of Prostate

FOX COLON LIVER

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Apr. 4

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Mar 12

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Apr. 4

4-4-80

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411 Division Ave. Haverstown, Pa.

William A. Nash M.D.

00-02983

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 5 6 0
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		LeRoy L. RICHESON		Apr 6 1986		6:51 PM	
1. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
M		W		12 - 17 - 36		49 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		USA				Washington MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital		machinist		trucking	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE	
Maryland		Washington		Hagerstown		1345 Salem Avenue 21740	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Kenneth Richesson		Maxine McAfee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
yes		Army 1960-1962 198-30-0454		Linda Richesson, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterioscl. coronary disease</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>yes</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>yes</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1986</u> to <u>April 6, 1986</u> , that (I) (we) lost							
saw the deceased alive on <u>above</u> , (I) (we) (did) (did not) view the body after death. <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>H. N. Weeks</u>		<u>MD</u>		<u>for certifying</u>		<u>April 6, 1986</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
<u>H. N. Weeks</u>		<u>550 North Av Hagerstown</u>		<u>MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
burial		Apr. 9, 1986		Rest Haven Cemetery		Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				APR 9 1986		<u>g</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner may be notified at any time.

BP

0-05082



00-03755

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 5 6 1

1. DECEASED NAME (TYPE OR PRINT) CAROL ANN RILEY			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR APR. 12 19 86			2b. HOUR 9:45 P M		
1. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 26, 1968	6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD APRIL 12 19 86	2d. HOUR 9:45 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Data Entry Clerk		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 14104 Schaeffer Rd. 20874			14. FATHER'S NAME FIRST MIDDLE LAST William Robert Lemley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Brenda Idian		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-06-8448		17. INFORMANT ADDRESS Brenda Lemley Finch, Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) E-812 - MOTOR VEHICLE/MOTOR VEHICLE COLLISION DUE TO, OR AS A CONSEQUENCE OF (b) (MASSIVE BASILAR SKULL FRACTURE) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MOMENTS								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:29 P.M. APR. 12 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FAILED TO STOP AT A STOP SIGN AND STRUCK BY ONCOMING VEHICLE			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) RURAL ROAD		21f. LOCATION STREET CITY OR TOWN COUNTY STATE INTERSECTION JEFFERSON PIKE & MT. ZION ROAD, NR. JEFFERSON, FREDERICK, MD.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Edward W. Ditto</i>			TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER			DATE SIGNED APR. 14, 1986		
EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.			ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Mpunt Olivet		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.	
24. FUNERAL DIRECTOR NAME Clint L. Molesworth, F.A., Damascus, Md.			25a. DATE REC'D. BY REGISTRAR APR 16 1986			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

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00-04207

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12562
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Alton William Rinard</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 13 86</i>		2b. HOUR <i>5:51 p.m.</i>	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 17, 1924		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.		
8. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICIAN			12b. KIND OF BUSINESS OR INDUSTRY STATE OF MD.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. CITY OR TOWN WASHINGTON		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ALTON LEE RINARD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PANSY M. POWERS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 195 16 4294		17. INFORMANT ADDRESS PAULINE M. RINARD SAME AS 13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *intracranial hemorrhage, spontaneous*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/10</i> 19 <i>86</i> to <i>4/13</i> 19 <i>86</i> , that (I) (we) lost saw this deceased alive on <i>4/13</i> 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert Bull</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4/15/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Bull</i>		22e. ADDRESS <i>1459 Potomac Ave. Hagerstown</i>					

23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL		23b. DATE 4/16/1986		23c. NAME OF CEMETERY OR CREMATORY TONOLWAY BAPTIST		23d. LOCATION CITY OR TOWN COUNTY STATE NEEDMORE, FULTON, PENNA. 17238	
24. FUNERAL DIRECTOR NAME <i>Robert Bull</i>				ADDRESS <i>Hancock MD.</i>		25a. DATE REC'D. BY REGISTRAR APR 21 1986	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

10-15-10

10-15-10



10-15-10

10-15-10

00-03480

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

12563

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes L Roach			2a. DATE OF DEATH MONTH DAY YEAR 04 10 86			2b. HOUR 8:18 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 11 99		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-54-6649T	
17. INFORMANT ADDRESS Avalon Manor Marsh Pike Hag. Md.										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) acute cva Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day yes										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W. B. KANG						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-10-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. B. KANG						22e. ADDRESS 1933 Va. Ave. Hagerstown, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-11-86			23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Gerald N. Minnich Hagerstown, Maryland						25a. DATE REC'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE Jane Davidson-Rodwell		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

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00-03157

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 2 5 6 4	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Harry E. Rockwell</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>4-2-86</i>					2b. HOUR <i>6:52pm</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Apr. 13, 1921</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i>			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington Co., MD.</i>				
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Co. Hosp.</i>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Printer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Printing</i>	
13a. STATE <i>Md.</i>					13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ernest F. Rockwell</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Blanche Shaffer</i>					13e. STREET ADDRESS / ZIP CODE <i>11 W. Baltimore St. 21740</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>WW II 177-16-0928</i>		17. INFORMANT ADDRESS <i>Judy Hawks 105 Broadway St., Hagerstown Md. 21740</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis of heart</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterial block</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>3-23-86</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>3-23-86</i> , 19 <i>86</i> , to <i>4-2-86</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>4-2-86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. R. Rodriguez</i>					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>4-2-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. R. Rodriguez</i>					22e. ADDRESS <i>381 W. Main Street, Hagerstown, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>4/5/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fairview</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Mercersburg Franklin Pa.</i>			
24. FUNERAL DIRECTOR <i>M. Limiger</i>					ADDRESS <i>17236 Mercersburg, Pa.</i>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>J. L. ...</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, the medical examiner must be notified of cause.

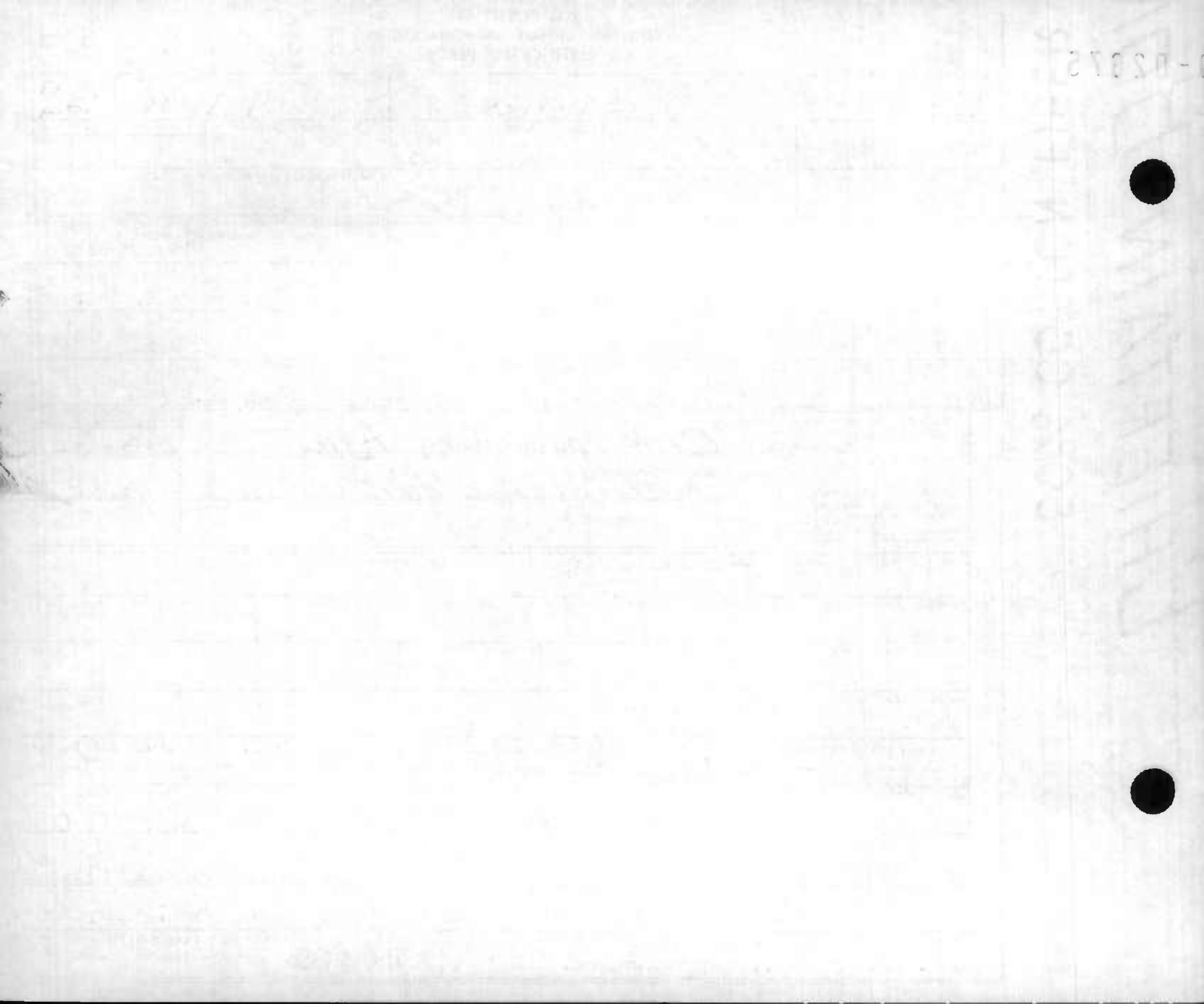
DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 5 6 5
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Lloyd Easton Samples		MONTH DAY YEAR 4-1-86		12:13 AM	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR December 21, 1915	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY automobile	
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. STREET ADDRESS / ZIP CODE 1742 Edgewood Hill, Apt. 204 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Samples		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Corda Dooley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 413-10-9604		17. INFORMANT ADDRESS Ruth Samples, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 1.23.73 , 19____, to 4.1 , 19 86 , that (1) (we) last saw the deceased alive on 3.17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.					
22b. SIGNATURE Charles C. Spencer MD		DEGREE MD		22c. DATE SIGNED 4-1-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles C. Spencer		22e. ADDRESS 1198 Kenly Ave Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE April 4, 1986		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR APR 04 1986		25b. REGISTRAR'S SIGNATURE Wendy Darden	

BP



00-05308

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8612566
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES ELMER SAUNDERS			2a. DATE OF DEATH MONTH DAY YEAR April 26, 1986		2b. HOUR 7:00pm	
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 29, 1915		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 71 YRS.		
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeder's Memorial Home		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY Maryland Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Saunders		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Reid		13e. STREET ADDRESS / ZIP CODE 21740		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 188-09-7767		17. INFORMANT ADDRESS Ruby I. Saunders Williamsport, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure - Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) CHF (Congestive Heart Failure) DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Andrew S. Bunn				22c. DATE SIGNED MAY 1 1986		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew S. Bunn	
22e. ADDRESS 100 Gething Lane, Keelyville, Md.				22f. DATE SIGNED MAY 1 1986			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-29-86		23c. NAME OF CEMETERY OR CREMATORY Manor Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Tilghmanton, Wash., Md.	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR MAY 1 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)
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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

A. E. Coffman Funeral Home, Inc.
 Hagerstown, Md.
 4-2-55 Manor Church Cemetery Tipton, Wash., Md.

Andrew
 128-32-7577 Mrs. I. Saunders, Williamsport, Md.
 332 Ohio Hallway Dr.
 Rain

Maryland Washington Department
 11 West Baltimore Street
 Baltimore
 Electrician Baltimore
 31740

West Virginia
 Washington County

Male
 White
 March 22, 1912
 April 26, 1985
 7:00pm



CHILMAN
 20% COTTON 50

00-05309

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 5 6 7
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (LAST OR FIRST) Robert Thomas SAUNDERS			2a. DATE OF DEATH MONTH DAY YEAR April 29, 1986		2b. HOUR 6:30 A.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 27, 1963		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 218 Garlinger Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired military		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 218 Garlinger Ave. 21740		14. FATHER'S NAME FIRST MIDDLE LAST Gary Saunders		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cheryl Ann Marrow		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	
16b. SOCIAL SECURITY NO. 218-92-6980		17. INFORMANT ADDRESS Gary Saunders, Hagerstown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cancer from Ewings sarcoma of the femur DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 580 Northern Avenue Hagerstown, Maryland 21740		22a. I certify that (I) (this hospital) attended the deceased from July 63 , to April 86 , that (I) (we) lost saw the deceased die on April 25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did) not see the body after death.		22b. SIGNATURE <i>Howard N. Weeks</i> DEGREE Howard N. Weeks, M.D.	
22c. DATE SIGNED 4/29/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D.		22e. ADDRESS 580 Northern Avenue Hagerstown, Maryland 21740		22f. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 1, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR MAY 1 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>		25c. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

LOW COTTON RIBED

CHIEFMAN BOWD



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00-03507

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 2 5 6 8

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Ethel</u> MIDDLE <u>Ellen</u> LAST <u>SHEELEY</u>			2a. DATE OF DEATH MONTH <u>04</u> DAY <u>07</u> YEAR <u>86</u>			2b. HOUR <u>2:25P</u> M					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>05</u> DAY <u>19</u> YEAR <u>15</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>71</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.					
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Western Maryland Center</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Smithsburg</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>5 S. Main Street 21783</u>			
14. FATHER'S NAME FIRST <u>Chester</u> MIDDLE <u> </u> LAST <u>Pogue</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Ida</u> MIDDLE <u>N.</u> LAST <u>Coy</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT ADDRESS <u>Sara Sheeley, Smithsburg, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerotic vascular dis.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 week</u> <u>Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus, old CVA and hypertension</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u> </u> P.M. <u> </u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) (this hospital) attended the deceased from <u>01/08</u> 19 <u>86</u> to <u>4/07</u> 19 <u>86</u> , that (X) (we) lost saw the deceased alive on <u>4/7</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Fe U. Porciuncula M.D.</u>						DEGREE <u> </u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/8/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Fe U. Porciuncula, M.D.</u>						22e. ADDRESS <u>Western Maryland Center, Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>Apr. 11, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem. Park</u>		23d. LOCATION CITY OR TOWN <u>Hagerstown, Wash.</u> COUNTY <u>Maryland</u> STATE <u>MD</u>					
24. FUNERAL DIRECTOR <u>MINNICH FUNERAL HOME</u> NAME <u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u> ADDRESS <u> </u>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Gula Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

CONTECUTW LIBCH



LIBRARY



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00-03739

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 6 9
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elva G. SHEFFLER			2a. DATE OF DEATH MONTH 4- DAY 13- YEAR 86			2b. HOUR 1:45 ^A				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH JAN. DAY 23 YEAR 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74		6. IF UNDER 1 YEAR MONTHS YRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Funkstown, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington ^{MD.}				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Village				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria Worker		12b. KIND OF BUSINESS OR INDUSTRY School Lunch		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Funkstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1 East Baltimore St. 21734	
14. FATHER'S NAME FIRST Frank MIDDLE O. LAST Stockslager			15. MOTHER'S MAIDEN NAME FIRST Blanche MIDDLE L. LAST Phleegee			16. ADDRESS 8 E. Baltimore St.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214- 09- 8342		17. INFORMANT ADDRESS Mr. Frank L. Stockslager, Funkstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE Auto Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Chronic Arteriosclerotic Disease DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Alzheimer's Disease										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/4 19 85 to 4/13 19 86 , that (I) (we) lost saw the deceased alive on 4/8 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE SADNEY ROVER STEIN						22c. DATE SIGNED 4/13/86		22d. ADDRESS FUNKSTOWN MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-15-86		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash. Co., Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. Boonsboro, Md. 21713						25a. DATE RECEIVED BY REGISTRAR APR 16 1986		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-0873

People	Place	Date	Place
Frank	Washington, D.C.	Jan. 24, 1915	Washington
Frank	Washington, D.C.		Washington
Frank	Washington, D.C.		Washington
Frank	Washington, D.C.		Washington
Frank	Washington, D.C.		Washington
Frank	Washington, D.C.		Washington
Frank	Washington, D.C.		Washington
Frank	Washington, D.C.		Washington
Frank	Washington, D.C.		Washington
Frank	Washington, D.C.		Washington

[Handwritten notes and signatures]

John H. Best, Jr., Secretary, Wash. D.C. 20543

Best Haven Cemetery, Washington, D.C.

00-05306

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Alter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

DHMH - 16 50M 1/76
(VR A 15 (4))1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 7 0
REG. NO.

1. DECEASED NAME (DIRECT OR PERM) FIRST MIDDLE LAST ETHEL R.uth SHEPPARD			2a. DATE OF DEATH MONTH DAY YEAR APRIL 25 1986		2b. HOUR MIN 4:50A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 3, 1921	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 64	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 824 Pine Street
14. FATHER'S NAME FIRST MIDDLE LAST Ellsworth Borens		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta Belle James			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-14-7047		17. INFORMANT ADDRESS 824 Pine Street William R. Sheppard Hagerstown, Md.	
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POORLY DIFFERENTIATED MUCINOUS CYSTADENO CARCINOMA OF RIGHT OVARY WITH ABDOMINAL METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) MITRAL VALVULAR DISEASE DUE RHEUMATIC DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 5 , 19 85 , to APRIL 25 , 19 86 , that (I) (we) last saw the deceased alive on APRIL 25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Edward W. Ditto</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO 111 MD		22e. ADDRESS 217 W. WASHINGTON ST. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-28-86	23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Pk. Hagerstown Wash. Md.	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.		ADDRESS Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR MAY 1 1986	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>	

BP

0-03542

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12571
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST Ruth MIDDLE R. LAST SHUPP Olive R. SHUPP			2a. DATE OF DEATH MONTH 4 DAY 8 YEAR 86			2b. HOUR 1:20p.m.						
3 SEX female		4 RACE white		5. DATE OF BIRTH MONTH March DAY 25 YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.						
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Village				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) legal secretary			12b. KIND OF BUSINESS OR INDUSTRY law firm			
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 940 Pennsylvania Ave. 21740		
14. FATHER'S NAME FIRST John MIDDLE I. LAST Whitemore				15. MOTHER'S MAIDEN NAME FIRST Belva MIDDLE B. LAST Frock								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 217 32 6967		17. INFORMANT ADDRESS Charles W. Shupp, Hagerstown, Md.						

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Aspiration Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Alzheimer's Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk.

2-3 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 13 Sept 1985 to 8 April 1986 , that (I) (we) last saw the deceased alive on 2 April 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W.N. Fender				DEGREE M.D.		22c. DATE SIGNED 9 April 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.N. Fender				22e. ADDRESS 138 E. Antietam St., Hagerstown MD 21740			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE April 11, 1986		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland COUNTY STATE 21740	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740 ADDRESS 							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PATTON ST., BALTIMORE, MARYLAND 21201

UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

PLANT
INDUSTRY

PLANT
INDUSTRY
BUREAU OF PLANT INDUSTRY
UNITED STATES DEPARTMENT OF AGRICULTURE



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UNITED STATES DEPARTMENT OF AGRICULTURE

PLANT
INDUSTRY

00-03955

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 2 5 7 2

1. DECEASED NAME (TYPE OR PRINT) Jean Marie Simmers		2a. DATE OF DEATH MONTH DAY YEAR 4 10 86		2b. HOUR 6:45 PM	
3. SEX F	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 8 18 35		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Waynesboro	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Penna.		13b. COUNTY Franklin	13c. CITY OR TOWN State Line	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Box #182 99999
14. FATHER'S NAME FIRST MIDDLE LAST John Brown Curfman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Sheffler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 160-48-8236		17. INFORMANT ADDRESS Walter N. Simmers, P.O. Box #182, State Line PA. 17263	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Liver Failure DUE TO, OR AS A CONSEQUENCE OF (b) non A non B Hepatitis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Acute Renal Failure; Cryptococcal Meningitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MARCH 13, 1986 to April 10, 1986 , that (I) (we) last saw the deceased alive on April 10, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. J. Delaney		DEGREE MD		22c. DATE SIGNED 4/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DMD J. DELAPORTAS, MD		22e. ADDRESS 7030 AK Hill Ave. Hagerstown MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 14/86		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro, PA., Franklin Co.		25a. DATE REC'D. BY REGISTRAR APR 16 1986			
24. FUNERAL DIRECTOR NAME ADDRESS John S. Snyder, Jr., 48 So. Church St. Waynesboro, PA. 17268		25b. REGISTRAR'S SIGNATURE John Davidson			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified and a medical certificate must be obtained.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

2000-00

0-03931

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 6 1 2 5 7 3 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Annie Mae Smith					2a. DATE OF DEATH MONTH DAY YEAR 04 09 86					2b. HOUR 6:28 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 21 1886		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeder's Memorial Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland				13b. COUNTY Frederick		13c. CITY OR TOWN Myersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Pleasant Walk 21773	
14. FATHER'S NAME FIRST MIDDLE LAST Emanuel Dusing				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan LaPole							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-5422		17. INFORMANT Lelia Smith		443 North Mulberry Street Hagerstown, MD 21740					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Recurrent aspiration</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Memoria, Alzheimer's dementia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R.C. Ricketts</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/10/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.C. Ricketts		22e. ADDRESS Geethy Lane		Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Apr. 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Pleasant Walk U.Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Pleasant Walk Frederick MD					
24. FUNERAL DIRECTOR L. R. Ricketts		ADDRESS Ricketts Funeral Home Myersville, MD 21773		25. APPROVED BY: (FURNITURE REGISTRY'S SIGNATURE) APR 16 1986 <i>John Davidson</i>							



20% COTTON



WILEY & SONS

00-05210

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

 FOR
 1- STATE
 REGISTRAR

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 5 7 4

1. DECEASED NAME (Last, first, middle) Mary A. Snyder			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4 26 1986			2b. HOUR MIN. 11 48		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 18, 1890	6. AGE (IN YEARS) LAST BIRTHDAY 96 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 26 1986		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School
13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Sharpsburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS W. Main St. 21782		
14. FATHER'S NAME FIRST MIDDLE LAST James nmi Snyder			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST E. Alverda Smith			16. SOCIAL SECURITY NO. no		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----			17. INFORMANT Louise Stauffer Hagerstown, MD 21740		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coarctation of the aorta DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Senile dementia, previous fractured pelvis and right hip								
19a. DATE OF OPERATION 4/26/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Senile dementia, previous fractured pelvis and right hip			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Allen D. H. MD		TITLE (SPECIFY) Deputy		M.D. MEDICAL EXAMINER		DATE SIGNED 4/26/86		
EXAMINER'S NAME (TYPE OR PRINT) Allen D. H. MD		ADDRESS 1610 Oak Hill Ave Hagerstown MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/29/86		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sharpsburg Washington Maryland		
24. FUNERAL DIRECTOR NAME Major M. Osborne		ADDRESS Williamsport, MD 21795		25a. DATE REC'D. BY REGISTRAR APR 30 1986		25b. REGISTRAR'S SIGNATURE Jana Davidson		

1980-1981

00-03523

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8612575
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELITEKA S BOURVILLE			2a. DATE OF DEATH MONTH DAY YEAR 4-6-86		2b. HOUR 7 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 27 1892		
6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 142 E. Irvin Avenue 21740		
14. FATHER'S NAME FIRST MIDDLE LAST Lemuel J. Powell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Scott		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 220-44-5032		17. INFORMANT Elizabeth S. Nichols, same as 13		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Gastrointestinal bleed; Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 86		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 4-6-86 to 4-6-86 , that (I) (we) last saw the deceased alive on 4/6/86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE [Signature]		
22c. DATE SIGNED 4/8/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Trace Jr. MD		22e. ADDRESS		

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-9-86		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Gerald N. Minnich Hagerstown, Maryland				25a. DATE REC'D. BY REGISTRAR APR 14 1986			
25b. REGISTRAR'S SIGNATURE [Signature]							

00-03512

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 7 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ella Mae STEWART			2a. DATE OF DEATH MONTH DAY YEAR 4/6/86		2b. HOUR 12:20pm
1. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR May 21, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Village		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST David Bothall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Mott		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lynn Meyers, Esq., Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 25 April 19 86 to 6 May 19 86 , that (I) (we) lost saw the deceased alive on 2 April 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. N. Fender		DEGREE M.D.		22c. DATE SIGNED 7 April 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. N. Fender		22e. ADDRESS 138 E. Antietam St Hagerstown MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 9, 1986		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, Md.		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR APR 11 1986	
25b. REGISTRAR'S SIGNATURE John K. ...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with p. 32 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on page 1, show any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 5 7 7
REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Lillie M Stouffer</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>April 10, 1986</i>			2b. HOUR <i>1:20P</i>				
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 5, 1906</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Mt. Lena, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.				
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Boonsboro</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Rfd. 2 Box 370 21713</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Irving Stottlemeyer</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Rebecca Houpt</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>213- 68- 6367</i>		17. INFORMANT ADDRESS <i>Mr. Glenn I. Stouffer, Boonsboro, Md. 21713</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Septic Left Lung Lobe Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Respiratory Sufficing</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>3 months</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Acute bronchitis resistant to right pneumonia & pleural effusion</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <i>80</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>19 80</i> to <i>April 10</i> , 19 <i>86</i> , that (I) was last saw the deceased alive on <i>April 10</i> , 19 <i>86</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.										
22b. SIGNATURE <i>Edison B. Moody</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>4/10/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edison B. Moody, M. D.</i>			22e. ADDRESS <i>College Rd., Hagerstown, Md. 21740</i>							
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>4-12-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lena Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Mt. Lena, Wash. Co., Md.</i>				
24. FUNERAL DIRECTOR <i>John H. Bast, Jr. Boonsboro, Md. 21713</i>						25a. DATE REC'D. BY REGISTRAR <i>APR 14 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John H. Bast, Jr.</i>		

BP. _____

1:30p
April 10, 1942

Female
Age 2, 1902

Mr. Tenn. M.I.
U. S. A.

Washington
Washington County Hospital
Om. name

Washington
Washington
D.C. 2 box 310
2113

Charles
Irving
Rebecca
John

213-25-652
Mr. Tenn. I. Secretary, Donors, M.I. 2113
D.C. 2 box 310

Alison B. Henry, M.I.
College M.I., Hagerstown, M.I. 2110

April 12-42
Mr. Tenn. Secretary
Mr. Tenn. Wash. Co., M.I.

John H. Hart, Jr. Donors, M.I. 2113

00-03134

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

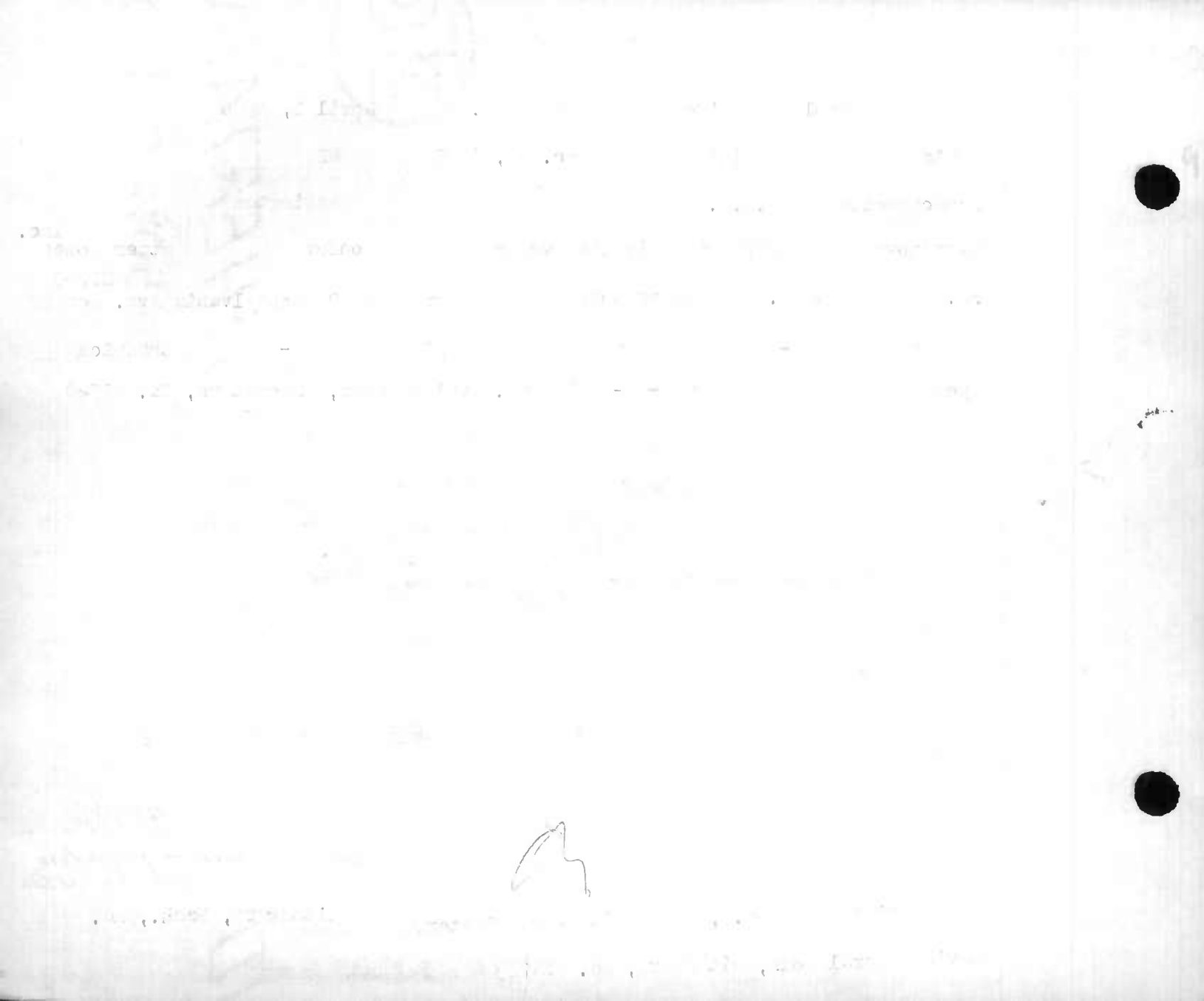
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 7 8
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Harold Wixon TABER SR.			2a. DATE OF DEATH April 1, 1986			2b. HOUR M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 17, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2377 Pennsylvania Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roofers		12b. KIND OF BUSINESS OR INDUSTRY Better Homes			
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2377 Pennsylvania Ave. Box 29 21740			
14. FATHER'S NAME FIRST MIDDLE LAST Abram - Taber				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie - Chadwick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) NN 11 217-28-6931		17. INFORMANT ADDRESS Mrs. Evelyn Taber, Hagerstown, Md. 21740							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Dysfunction, COPD</u> (c) <u>Chronic Atrial Fibrillation, Recurrent CHF</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>pulmonary dysfunction, hyperlipidemia, MI</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 23</u> , 19 <u>83</u> , to <u>3/26</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3/26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Francisco L. Andrade</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4/2/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FRANCISCO L. ANDRADE</u>				22e. ADDRESS <u>363 S. Cleveland Ave - Hagerstown</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Wash., Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Davis Funeral Home, Smithsburg, Md. 21783				25. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Twyman-Randall</u>					

BP



0-03161

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the funeral director. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must complete the following information.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div> <div>FOR 1. STATE REGISTRAR</div> <div>8 6 1 2 5 7 9 REG. NO.</div> </div>									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Merle Edgar TOMS						2a. DATE OF DEATH MONTH DAY YEAR April 3, 1986		2b. HOUR M AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 19, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Tool Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Md. Fred. Smithsburg						13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4718 Foxtower Rd. 21783	
14. FATHER'S NAME FIRST MIDDLE LAST Sheridan - Toms						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olivia C. Wolfe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 173-03-3335		17. INFORMANT ADDRESS Mrs. Pearl N. Toms, Smithsburg, Md., 21783					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) M.I., Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Emphysema, High Blood Pressure, Granulomatous Hepatitis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/13 19 81 , to 4/3 19 86 , that (I) (we) last saw the deceased alive on 3/31 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James A. Frizzell, M.D.						DEGREE M.D.		22c. DATE SIGNED 4/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James A. Frizzell, M.D.						22e. ADDRESS 300 Park Avenue, Frederick, Maryland 21701			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 6, 1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Foxville, Fred., Md.			
24. FUNERAL DIRECTOR NAME Dennis L. Davis						25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	
Davis Funeral Home, Smithsburg, Md., 21783									

VOID

CERTIFICATES #

12580

THUR

12588



0-05885

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 5 8 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LENORE THEODOSIA TRUAX			2a. DATE OF DEATH MONTH DAY YEAR April 18, 1986		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 15 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hancock	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 203 Maryland Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hancock	
14. FATHER'S NAME James Albert O'Rourke			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nina Lillian Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-44-9726		17. INFORMANT ADDRESS Gene O. Truax 16 Penna. Ave. Hancock, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **Atherosclerotic Cardiovascular Dis.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 4, 1980 to April 18, 1986 , that (I) (we) lost saw the deceased alive on 4-16, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) use the body after death.			
22b. SIGNATURE Richard J. Grove		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN	22c. DATE SIGNED 5/2/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/22/86	23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Needmore Fulton Penna.
24. FUNERAL DIRECTOR NAME Richard J. Grove		ADDRESS Hancock Md	25a. DATE REC'D. BY REGISTRAR MAY 7 1986
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner and the medical examiner's office must be notified at once.

[Faint, mostly illegible handwritten text covering the majority of the page]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12590
REG. NO.

1- FOR
STATE
REGISTRAR

David H

1. DECEASED NAME
(TYPE OR PRINT)

David Harold H.

Vance

2a. DATE OF DEATH MONTH DAY YEAR
4-9-86

2b. HOUR
8:24 A.M.

3. SEX
m

4. RACE
W

5. DATE OF BIRTH
MONTH DAY YEAR
3 1 29

6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS

IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 72 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. C. - Md.

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Washington MD.

10. CITY OR TOWN OF DEATH
Hagerstown, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington County Hospital

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
maintenance

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland

13b. COUNTY
Washington

13c. CITY OR TOWN
Hagerstown

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE
508 Ridge Ave. 21740

14. FATHER'S NAME
FIRST MIDDLE LAST
David M. Vance

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Zura V. Gordon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
korean 212 24 6008

17. INFORMANT ADDRESS
Eleanor V. Vance, Hagerstown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) Severe Chronic Obstructive Pulmonary Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ABDUL WATHEED MD

1610 - OAK HILL AVE. HAG. MD. 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
burial

23b. DATE
Apr. 12, 1986

23c. NAME OF CEMETERY OR CREMATORY
Cedar Lawn Mem. Park

23d. LOCATION
CITY OR TOWN COUNTY STATE
Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR
NAME ADDRESS
MINNICH FUNERAL HOME
415 E. Wilson Blvd., Hagerstown, Md. 21740

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

APR 14 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

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APR 4 1900

00-02676

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Milton O. WARRENFELTZ					2a. DATE OF DEATH MONTH April DAY 1 YEAR 1986		2b. HOUR 6:45 P.M.		
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 10 DAY 19 YEAR 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner		12b. KIND OF BUSINESS OR INDUSTRY distributing co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE near Ringgold Route 5, Box 214 21740		
14. FATHER'S NAME FIRST Oscar MIDDLE G. LAST Warrenfeltz			15. MOTHER'S MAIDEN NAME FIRST Bessie MIDDLE LAST Koogle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. W.W.II 219 05 2152		17. INFORMANT ADDRESS Mary P. Warrenfeltz, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for a) (b) (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rectal Carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Gram Negative Sepsis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Gram Negative Sepsis									
19a. DATE OF OPERATION 3/30		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED prostate				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 					
22. I certify that (1) (this hospital) attended the deceased from 3/30 19 86 to present 19 86 that (1) (we) last saw the deceased alive on 4/1/86 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did (did not) view the body after death.									
22a. SIGNATURE Charles R. Chaney M.D. DEGREE M.D.				22b. ADDRESS 363 S. Cleveland Ave. Hag. Md.		22c. DATE SIGNED 4/1/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles R. Chaney M.D.				22e. ADDRESS 363 S. Cleveland Ave. Hag. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE April 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland COUNTY STATE 			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 15 E. Wilson Blvd., Hagerstown, Maryland 21740				25a. DATE REC'D. BY REGISTRAR APR 04 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

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9th April 1941
Mr. J. H. ...
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-05597

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR **Francis Lloyd Webb** **CERTIFICATE OF DEATH** **86 11 25 92**
REG. NO.

1. DECEASED NAME (Type or Print) Francis Lloyd Webb			2a. DATE OF DEATH MONTH DAY YEAR Apr 29 1986		2b. HOUR 12 MIN 14	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1896		
7a. BIRTHPLACE (State or Foreign Country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (in years last birthday) 90		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) Washington County Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
12a. USUAL OCCUPATION (Type of work for most of working life) Car Inspector		12b. KIND OF BUSINESS OR INDUSTRY Railroad		13a. STREET ADDRESS / ZIP CODE 335 Liberty Street 21740		
14. FATHER'S NAME FIRST MIDDLE LAST William Holland Webb		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Ellen Pearl				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-10-9431		17. INFORMANT ADDRESS 335 Liberty Street Hagerstown, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-24-1985 to 4-29-1986 that (I) last saw the deceased alive on 4-29-1986 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) we did not view the body after death.							
22b. SIGNATURE Charles C. Spencer MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-29-86			
22d. PHYSICIAN'S NAME (Type or Print) Charles C. Spencer				22e. ADDRESS 1198 Kenly Ave Hagerstown			

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-1-86		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR MAY 5 1986		25b. REGISTRAR'S SIGNATURE John A. Swider	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-0-501

FRANCIS LLOYD WEBB

Francis Lloyd Webb

Male	White	April 1, 1886	90
Maryland	U.S.A.		Washington County

Hagerstown Washington County, Maryland
 21740
 722 Liberty Street

William Holland Webb
 Sarah Ellen Pearl
 335 Liberty Street
 Hagerstown, Md.
 337-10-421

Burial
 3-1-00
 Best Haven Cemetery Hagerstown, Washington, Md.
 A.R. Collins Funeral Home, Inc.
 Hagerstown, Md.

00-03483

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

12593

1. DECEASED NAME (TYPE OR PRINT) Ronald Lee WHITTINGTON			2a. DATE OF DEATH MONTH DAY YEAR April 10, 1986		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR May 3, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) labor		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2228 Beverly Drive 21740
14. FATHER'S NAME FIRST MIDDLE LAST Kenneth Whittington		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Martin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (1936-1957) Army 216 22 1863	17. INFORMANT ADDRESS Rhoda A. Whittington, Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PRESUMED MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Apr. 12, 1986	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a. DATE REC'D BY REGISTRAR APR 14 1986		
			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

BP

89251

10000-3

10000-3

00-03533

8

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain information from pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic explanation, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH DAY YEAR	
Marshall		Emmons		WILEY		April 9, 1986		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
male		white		July 20, 1927		58		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Maryland		USA				Washington		Hagerstown	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. INSIDE CITY LIMITS?	
315 Central Avenue		truck driver		construction		315 Central Ave. 21740		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Maryland		Washington		Hagerstown		Stanley P. Wiley		Bertha Bittinger	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
yes		1945-1957		216-22-6737		Laura B. Wiley, Hagerstown, Md.			
						(b) <u>Cardiopulmonary arrest</u>			
						(c) <u>Bronekogenic carcinoma</u>			
						(d) <u>Diabetes mellitus</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)									
<u>emphysema, carcinoma of rectum</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		HOUR A.M. MONTH DAY YEAR				21f. LOCATION		CITY OR TOWN COUNTY STATE	
21f. LOCATION		21g. PLACE OF INJURY		21h. LOCATION		21i. LOCATION		CITY OR TOWN COUNTY STATE	
21g. PLACE OF INJURY		21h. LOCATION		21i. LOCATION		21j. LOCATION		CITY OR TOWN COUNTY STATE	
21j. LOCATION		21k. LOCATION		21l. LOCATION		21m. LOCATION		CITY OR TOWN COUNTY STATE	
21m. LOCATION		21n. LOCATION		21o. LOCATION		21p. LOCATION		CITY OR TOWN COUNTY STATE	
21p. LOCATION		21q. LOCATION		21r. LOCATION		21s. LOCATION		CITY OR TOWN COUNTY STATE	
21s. LOCATION		21t. LOCATION		21u. LOCATION		21v. LOCATION		CITY OR TOWN COUNTY STATE	
21v. LOCATION		21w. LOCATION		21x. LOCATION		21y. LOCATION		CITY OR TOWN COUNTY STATE	
21y. LOCATION		21z. LOCATION		22a. SIGNATURE		22b. DATE SIGNED		22c. DATE SIGNED	
22a. SIGNATURE		22b. DATE SIGNED		22c. DATE SIGNED		22d. DATE SIGNED		22e. DATE SIGNED	
22b. DATE SIGNED		22c. DATE SIGNED		22d. DATE SIGNED		22e. DATE SIGNED		22f. DATE SIGNED	
22c. DATE SIGNED		22d. DATE SIGNED		22e. DATE SIGNED		22f. DATE SIGNED		22g. DATE SIGNED	
22d. DATE SIGNED		22e. DATE SIGNED		22f. DATE SIGNED		22g. DATE SIGNED		22h. DATE SIGNED	
22e. DATE SIGNED		22f. DATE SIGNED		22g. DATE SIGNED		22h. DATE SIGNED		22i. DATE SIGNED	
22f. DATE SIGNED		22g. DATE SIGNED		22h. DATE SIGNED		22i. DATE SIGNED		22j. DATE SIGNED	
22g. DATE SIGNED		22h. DATE SIGNED		22i. DATE SIGNED		22j. DATE SIGNED		22k. DATE SIGNED	
22h. DATE SIGNED		22i. DATE SIGNED		22j. DATE SIGNED		22k. DATE SIGNED		22l. DATE SIGNED	
22i. DATE SIGNED		22j. DATE SIGNED		22k. DATE SIGNED		22l. DATE SIGNED		22m. DATE SIGNED	
22j. DATE SIGNED		22k. DATE SIGNED		22l. DATE SIGNED		22m. DATE SIGNED		22n. DATE SIGNED	
22k. DATE SIGNED		22l. DATE SIGNED		22m. DATE SIGNED		22n. DATE SIGNED		22o. DATE SIGNED	
22l. DATE SIGNED		22m. DATE SIGNED		22n. DATE SIGNED		22o. DATE SIGNED		22p. DATE SIGNED	
22m. DATE SIGNED		22n. DATE SIGNED		22o. DATE SIGNED		22p. DATE SIGNED		22q. DATE SIGNED	
22n. DATE SIGNED		22o. DATE SIGNED		22p. DATE SIGNED		22q. DATE SIGNED		22r. DATE SIGNED	
22o. DATE SIGNED		22p. DATE SIGNED		22q. DATE SIGNED		22r. DATE SIGNED		22s. DATE SIGNED	
22p. DATE SIGNED		22q. DATE SIGNED		22r. DATE SIGNED		22s. DATE SIGNED		22t. DATE SIGNED	
22q. DATE SIGNED		22r. DATE SIGNED		22s. DATE SIGNED		22t. DATE SIGNED		22u. DATE SIGNED	
22r. DATE SIGNED		22s. DATE SIGNED		22t. DATE SIGNED		22u. DATE SIGNED		22v. DATE SIGNED	
22s. DATE SIGNED		22t. DATE SIGNED		22u. DATE SIGNED		22v. DATE SIGNED		22w. DATE SIGNED	
22t. DATE SIGNED		22u. DATE SIGNED		22v. DATE SIGNED		22w. DATE SIGNED		22x. DATE SIGNED	
22u. DATE SIGNED		22v. DATE SIGNED		22w. DATE SIGNED		22x. DATE SIGNED		22y. DATE SIGNED	
22v. DATE SIGNED		22w. DATE SIGNED		22x. DATE SIGNED		22y. DATE SIGNED		22z. DATE SIGNED	
22w. DATE SIGNED		22x. DATE SIGNED		22y. DATE SIGNED		22z. DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
22x. DATE SIGNED		22y. DATE SIGNED		22z. DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
22y. DATE SIGNED		22z. DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
22z. DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE	
burial		Apr. 12, 1986		Greenlawn Mem. Park		Williamsport, Wash., Maryland			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
MINNICH FUNERAL HOME		APR 14 1986		John E. Wilson		John E. Wilson		John E. Wilson	
415 E. Wilson Blvd., Hagerstown, Md. 21740									

15244

00-03223



0-03335

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		LYDIA ALICE WINDERS		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8612595 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Lydia Alice Winders				2a. DATE OF DEATH MONTH DAY YEAR April 5, 1986		2b. HOUR 9:30 P.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 26, 1892		6. AGE (LAST BIRTHDAY) 93 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.	
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahmney-Keedy Memorial Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Bookbinding co.	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Riley Winders		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Virginia Routzahn		13e. STREET ADDRESS / ZIP CODE 864 Mulberry Avenue 21740			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-09-7267		17. INFORMANT Naomi R. Harbaugh		ADDRESS 866 Mulberry Avenue Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:25 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 725		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 73			
22a. I certify that (I) (this hospital) attended the deceased from 2-15-86 , 19 86 , to 73 , 19 86 , that (I) (we) last saw the deceased alive on 2-15-86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. E. Lardizabel		DEGREE Dr. E. Lardizabel		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-7-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. E. Lardizabel		22e. ADDRESS 382 S. Cleveland Ave., Hagerstown, MD 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-8-86		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.		Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR APR 11 1986		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

BP

0-00000

LYDIA ALICE
WINDERS

2393

LYDIA ALICE

August 26, 1892

Female

U.S.A.

Bookkeeper
217AO

864 Mulberry Avenue
Washington, D.C.

William Riley Winters
864 Mulberry Avenue
Washington, D.C.
217AO-99-1203

WINTER
%
217AO

Burial
Rose Hill Cemetery, Washington, D.C.

A.R. Coffman Funeral Home, Inc.
Washington, D.C.

-03135

10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 12596

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Florence</u> MIDDLE <u>A.</u> LAST <u>WYLY</u> <u>Wylly</u>		2a. DATE OF DEATH MONTH <u>April</u> DAY <u>3</u> YEAR <u>1986</u>		2b. HOUR <u>8 P.M.</u>	
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>June</u> DAY <u>2</u> YEAR <u>1924</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>61</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Illinois</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington County</u> MD.		10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>Penna.</u>		13b. COUNTY <u>Franklin</u>		13c. CITY OR TOWN <u>Waynesboro</u>	
14. FATHER'S NAME FIRST <u>Gustaf</u> MIDDLE <u>A.</u> LAST <u>Antonson</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Marie</u> MIDDLE <u>J.</u> LAST <u>Johnson</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>577-32-4038</u>		17. INFORMANT <u>Robert S. Wylly</u> ADDRESS <u>Penna. 17263</u> <u>P.O. Box 371, State Line</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ovarian Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>86</u>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 84</u> , 19 <u>84</u> , to <u>4/3</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/3</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <u>Frederic H. Kass III</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>4/4/86</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frederic H. Kass III</u>		22d. ADDRESS <u>1825 Hollowell Rd Hagerstown MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>4/5/1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Falls Church Fairfax Va.</u>		24. FUNERAL DIRECTOR NAME <u>Grove Funeral Home</u> ADDRESS <u>Waynesboro Pa</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 8 1986</u>	
25b. REGISTRAR'S SIGNATURE <u>John R. ...</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-03502

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

12597
12597

1. DECEASED NAME (TYPE OR PRINT) VIOLA Estella WYATT			2a. DATE OF DEATH MONTH DAY YEAR 4-5-86			2b. HOUR 0630 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 29, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Baltimore 13d. CITY OR TOWN Baltimore				13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 7915 Main St. 21226			
14. FATHER'S NAME FIRST MIDDLE LAST Harry Monroe Cook				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margie Elizabeth Hose					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-20-5768		17. INFORMANT ADDRESS Joye Largent Rt.1 Bx#206 Falling Waters, WV					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATO-RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MICRONODULAR CIRRHOSIS & SUBACUTE HEPATITIS. DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION 12-29-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding pyloric chenal ulcer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I (this hospital) attended the deceased from 12-29 , 19 86 , to 4-5 , 19 86 , that (I (we) last saw the deceased alive on 4-5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.									
22b. SIGNATURE E. Haworth M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-5-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 29, 1986		23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marlowe Berkeley West Virginia			
24. FUNERAL DIRECTOR NAME Major M. Osborne Williamsport, MD 21795				25a. DATE REC'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE Sub. A. ...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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